



Registration Form

WELCOME TO OUR OFFICE

Date: _____

New

SRMF Account Number: _____

Update

Patients Name:		Home Phone:	Birthdate: / /	Marital Status:
Residence Address:		City:	State:	Zip Code:
Social Security Number:		E-Mail Address:		
If Patient Is a Child, Give Parent or Guardian's Name:		Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Cantonese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin <input type="checkbox"/> Other _____		
Name of Employer / Occupation:	Business Address:		Business Phone:	
Do You Have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, How Do You Intend To Pay? <input type="checkbox"/> Check <input type="checkbox"/> Cash		
Is your Medicare benefit assigned to Kaiser or another HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No		Credit Card - <input type="checkbox"/> VISA <input type="checkbox"/> MC # _____		
Primary Insurance Company Name and Address: *				
Subscriber Name:		Policy #:	Is This Through Your Employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Secondary Insurance Company Name and Address:				
Subscriber Name:		Policy #:	Medical #:	Medicare #:
Spouse's Name:		Home Phone: (If Different)		Birth date: / /
Residence Address: (If Different)		City:	State:	Zip Code:
Name and Address Of Spouse's Employer:				Business Phone:

Sutter Regional Medical Foundation Registration Form

Person Financially Responsible For This Account: <input type="checkbox"/> Self <input type="checkbox"/> Other _____		Name:	
Relationship To Patient:	Address:	Phone:	Driver's License #:
Guarantor Employer:		Employer Address:	
Worker's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury: / /	Name and Address Of Company:	
Company Phone:		Treatment Authorized By:	
In Case Of Emergency, Who Should We Contact?		Emergency Phone #:	
Nearest Friend or Relative Not Residing With You:			
Relationship To Patient:		Phone #:	
Address Of Friend Or Relative:			
If Patient Is A Child, Who May Authorize Treatment For The Child:		Relationship To Child:	Phone #:
Whom Should We Thank For Referring You?		Address:	
Do You Authorize Release Of Your Medical Information To Anyone Besides Your Insurance Carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No		If So, Whom?	

- *I authorize this office to release to the named insurance company (and employer if covered under Worker's Compensation) any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.*
- *I authorize direct payment to Sutter Regional Medical Foundation any insurance benefits otherwise payable to me for services as described.*
- *I consent to the provision of medical, surgical, laboratory, and radiological services deemed necessary for treatment of any illness injury by Sutter Regional Medical Foundation. and their physicians, employees and agents.*

Patient, Parent or Guardian Signature: _____ Date: _____