Chino Hills Family Medical Group

Patient Registration Form

Patient Personal Information	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female
Last Name:	First Name: Middle Initial:
Date of Birth: / /	Social Security #: - -
Home Phone ( )	Work Phone: ( ) Cell: ( )
Address:	Apt #: City: State: Zip:
Patient/Responsible Party Information	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Last Name:	First Name: Middle Initial:
Date of Birth: / /	Social Security #: - -
Home Phone ( )	Work Phone: ( ) Cell: ( )
Address:	Apt #: City: State: Zip:
Patient Insurance Information	*Please present insurance cards to receptionist.*
Primary Insurance Name:	Policy #: Group #
Address:	City: State: Zip:
Name of Insured:	Date of Birth: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Secondary Insurance Name:	Policy #: Group #
Address:	Apt #: City: State: Zip:
Name of Insured:	Date of Birth: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Patient Portal	The patient portal is a secured tool for sending and receiving messages with the practice. By providing your email address, you agree to activating your Patient Portal.
Do you wish to activate your patient portal? ☐ NO ☐ YES If YES, please provide email address:	
Preferred Pharmacy	
Name:	
Address:	City: State: Zip:
Emergency Contact	
Name:	Relationship:
Address:	Apt #: City: State: Zip:
Home Phone ( )	Work Phone: ( ) Cell: ( )
Additional Information	
Race:	Ethnicity: Preferred Language: Decline to Answer
Do you have an Advanced Directive for anyone in your family over the age of 18? ☐ YES ☐ NO	

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Chino Hills Family Medical Group and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Signature:_____