FREMONT RHEUMATOLOGY - REGISTRATION FORM

Name: _____ **DOB:** _____
Last, First MI MM / DD / YYYY

Address: _____ SS#: _____

_____ Sex: Female / Male

EMAIL: _____ **Phone: Home** _____-_____-_____

☐ **Government Issued Photo ID – Type: _____ # _____** **Phone: Cell** _____-_____-_____

Employer: _____ □ Full-time □Part-time □_____ Phone: Work _____-_____-_____

Marital Status: Single / Married/ Widowed/ Separated/ Divorced/ Domestic Partner Race: _____ Ethnic Group: _____

Preferred Language: _____ □ Interpreter requested on: _____ for new pt appt (AAH:510-747-4567)

Preferred Contact Method: Phone / Text Message _____ [initial] / Mail_____ / Email _____ [initial] / Patient Portal

Preferred Reminder Method: Cell / Home / Work / Text / Email / Patient Portal / Mail

Primary Insurance: _____ □Referral Required (AAH, Hills, HMO, Tricare) □Medicare Advantage Plan

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder: _____ **DOB:** _____ **SS#:** _____ **Relationship:** _____

Secondary Insurance: _____ □Medi-CAL □Tricare □ Commercial Secondary □_____

Policy #: _____ Group #:_____ Effective Date: _____

Policy Holder: _____ **DOB:** _____ **SS#:** _____ **Relationship:** _____

Pharmacy/Drug Coverage / Medicare Part D: _____ ID: _____ Effective: _____
RxBin: _____ RxPCN: _____ RxGroup: _____

Preferred (name, city, road) **Preferred** **Preferred**
Pharmacy: _____ **Lab:** _____ **Imaging:** _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred By: _____ **Primary Care MD**: _____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company(ies), and assign directly to Fremont Rheumatology all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

_____ _____ _____
Responsible Party Signature Relationship Date & Time

Appointment Date: _____ Dr.Shibuya /Dr.Elias Time: _____AM / PM Best Appt Time:_____
Record Request from PCP sent date: _____ Record Request received _____
Lab request: _____ Imaging: _____ Office Use: Form last Updated 11/02/2014