

MT. DIABLO INTEGRATED WELLNESS CENTER

140 MAYHEW WAY #902

PLEASANT HILL, CA 94523

Phone: (925) 935-5425, Fax: (925) 947-2671

NEW PATIENT REGISTRATION FORM

Patient Name: _____

Address: _____

Social Sec #: _____

Sex: Male Female Birth Date: _____ Age: _____

Marital Status: Single Married Divorced Widowed

How did you learn about us: Friend Relative Yellow Pages

Physician: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Who is financially responsible for payment for these services?

Self Spouse Parent/Guardian Workers Comp Other: _____

Responsible Party or Bill to Information:

Full Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Birth Date: _____ Age: _____ Social Sec. #: _____

Employer: _____

Insurance Information:

Insurance company name: _____ Plan Name: _____

Type of plan: PPO POS HMO Medicaid Medicare Tricare Medicare HMO

WC Lien

Policy #: _____ Group #: _____

Copay: _____ Is plan through employer? Yes No

Employer Address: _____ Occupation: _____

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to MDI Wellness as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Signature: _____

Date: _____