Achieve Medical Group

23000 Crenshaw Blvd. #208
Torrance, CA 90505

PATIENT REGISTRATION FORM

Please present insurance cards to the receptionist so copies may be made.

PATIENT INFORMATION (Please Print)

Name_____
Last , First , M.I.
Mailing
Address_____City/State/Zip_____

Cell Phone (____)_____ Home Phone (____)_____

Date of Birth ____/____/____ Marital Status_____ Sex_____ SS#_____

E-Mail Address: _____ Race/Ethnicity: _____

SPOUSE, PARENT OR RESPONSIBLE PARTY (if different from patient)

Name_____
Last , First , M.I
Address_____
City State Zip
Home Phone (____)_____Work Phone (____)_____ SS#_____

Date of Birth ___/___/___ Sex_____

EMERGENCY CONTACT INFORMATION - In case of Emergency, who should be notified?

Name/Relationship _____ Phone (_____)_____

Name/Relationship _____ Phone (_____)_____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Co._____ **Secondary** Insurance Name _____

Name of policy owner if other than patient_____
Date of Birth of policy owner if other than patient_____
Patient relationship to policy owner: _____ Self _____Spouse _____ Child _____Other

EMPLOYER INFORMATION:

Employer Name_____ Employer Phone_____

Employer Address_____

How did you hear about us?_____

If applicable, Previous Primary Care Physician? _____

MAIN PURPOSE OF TODAY'S VISIT: _____
_____

CURRENT MEDICATIONS: _____
_____

Medication Allergies:
_____

How many cigarettes do you smoke per day? _____
How much alcohol do you consume per week? _____
How much caffeine do you consume per day? _____
What do you do for exercise? _____

Do we have your permission to:
Leave a message on your answering machine at home? ___ Yes ___No
Leave a message at your place of employment? ___ Yes ___No

Discuss your medical condition with any member of your household? ___ Yes ___No
If yes, whom_____ Relationship_____ Contact ( ) _____

As Per Achieve Medical Group's notice of Privacy Practices I authorize the release of medical information, including HIV STATUS to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to my physicians.

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies our staff is trained to inform you of the financial policies of this office**.**

Patient Signature_____ Date_____