VICTORY PHYSICIANS

A1

REGISTRATION FORM

(Please Print)

		Today's Date:

Last: First: Middle:			Current Primary Care Physician:		
Is this your legal name? Yes ☐ No ☐	If not, what is your legal name?	Former name (if any):	Birth date: / /	Age:	Sex: ☐ ☐
Physical Street Address:		Social Security Number:	Home Phone: ( )		
Mailing Address:	City:	State:	ZIP Code:		
Occupation:	Employer Name: Employer Address:		Employer Phone: ( )		
Chose clinic because/Referred to clinic by (please check one box):		Dr.:	☐ Insurance Plan	☐ Hospital	
Family/Friend	☐ Internet	☐ Close to home/work	☐ Phone Book	☐ Newspaper:	Other:
E-Mail:	Cell Phone: ( )		Marital Status:		

INSURANCE INFORMATION

(Please give your insurance card and Driver's License to the front office staff member.)

Guarantor if pt. is a minor:	Birth date: / /	Mailing Address (if different):	Home Phone: ( )
Is this person a patient here? ☐ Yes ☐ No	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent/Guardian		Other:
Occupation:	Employer:	Employer Address:	Employer Phone: ( )
Is this patient covered by insurance? ☐ Yes ☐ No	Effective Date of Insurance:		

Please indicate Primary Insurance:	Aetna ☐	Blue Cross ☐	Blue Shield ☐	Cigna ☐	First Health ☐
Medicare ☐	☐ Nationwide	PacifiCare ☐	United Healthcare ☐	Other:	

Subscriber's Name on Insurance:	Subscriber's S.S. Number:	Birth date: / /	Policy Number:	Group No.:	Co-Payment: $
Subscriber's Mailing Address:			Subscriber's Phone:		
Patient's relationship to subscriber:	Self ☐	Spouse ☐	Child ☐	Other	

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Policy No.:	Group No.:
Subscriber's Mailing Address:		Subscriber's Phone:	
Patient's relationship to subscriber:	Self ☐ Spouse ☐ Child ☐	Other	

EMERGENCY INFORMATION

Emergency Contact Name:	Relationship to patient:	Home Phone: ( )	Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Frank Arian, M.D., a California Professional Corporation dba Victory Physicians or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*