Armando J. Jarquin, MD, PA
PATIENT REGISTRATION

PATIENT DATA

Name: _____
Last First Middle

Address: _____
Street

_____
City State Zip

Phone: H: _____ W: _____ Cell: _____

Date Of Birth: _____ Social Security #: _____

Driver's License#: _____

Marital Status: S M W D Sex: M F Race: _____ Age: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

If patient under 18, who does the child live with: Name: _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Others

Social Security #: _____ Phone: _____

Address: _____

EMER-GENCY

Emergency Contact: _____

Relationship: _____

Home Phone: _____ Work Phone: _____

INSURANCE

PRIMARY INSURANCE

Ins. Company: _____ Phone: _____

Plan Type: _____ Employer's Name: _____

Policy Holder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to patient: _____ Driver's License # _____

Policy No. (Medicare No.): _____ Group No.: _____

SECONDARY INSURANCE

Ins. Company: _____ Phone: _____

Plan Type: _____ Employer's Name _____

Policy Holder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to patient: _____ Driver's License #: _____

Policy No. (Medicare No.): _____ Group No.: _____

I hereby authorize Armando J. Jarquin, MD, PA to release any information of my treatment to my insurance company, third-party payer or employer, as required of claims filed to facilitate reimbursement, health plan administration, quality assurance, and complaints/grievances. I understand that the specific information to be released may include history, diagnosis and/or treatment of drugs, mental related illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize payment to be made to Armando J. Jarquin, MD, PA for any medical or surgical services provided. I understand that for services not covered, or Armando J. Jarquin, MD, PA is unable to verify eligibility that I am responsible for all charges incurred for services rendered. This statement will be into effect unless revoked in writing. I understand that there will be a $25 charge for each appointment missed or not cancelled 24 hours in advanced.

SIGNATURE: _____ **DATE:** _____