Saman B. Chubineh, M.D.

REGISTRATION FORM

Please answer all questions in full

Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION				
Patient's last name: First:	Middle:	Salutation:	Marital status:	
Is this your legal name?	If not, what is your legal name?	Birth date:	Age:	Sex:
Address:	City:	Zip code		
Home phone no.:	Cell phone no.:	E-mail Address:		
Social Security Number:	Ethnicity/Race	Preferred Language		
Please provide your pharmacy name and Location				
Occupation:	Referring Physician/How you came to our practice:			

INSURANCE INFORMATION (Please give your insurance card(s) to the receptionist (both primary and secondary).)		
Insured's Name (if different than patient)	Insured's address (if different)	Insured's Birth Date:
Patient Relationship to Insured:	Insured's Social Security Number:	Co-Payment Amount

IN CASE OF EMERGENCY			
Name of Emergency Contact:	Relationship to patient:	Home phone no.:	Work phone no.:

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 Saman B. Chubineh, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date