REGISTRATION

RHONDA J. MYERS, Ph.D., M.D.

(949) 552-312
FAX (949) 552-372

This information is confidential. We appreciate your co-operation in filing out this form as completely as possible

Date: / /

SEX ☐ M ☐ F

Date of Birth / /	Age:

PATIENT INFORMATION

PATIENT FIRST NAME	MIDDLE	LAST NAME	HOME TELEPHONE ( )
STREET ADDRESS	CITY AND STATE	ZIP	CELL TELEPHONE ( )
REFERRED BY	STREET	CITY AND STATE	ZIP CODE	TELEPHONE ( )
PATENT'S PHYSICIAN	STREET	CITY AND STATE	ZIP CODE	TELEPHONE ( )

RESPONSIBLE PARTY INFORMATION (Give full name and Relationship of Person Legally Responsible)

FIRST NAME	MIDDLE	LAST NAME	DOB	RELATIONSHIP TO PATIENT
HOME ADDRESS STREET	CITY AND STATE	ZIP CODE	TELEPHONE ( )	
EMPLOYED BY	STREET	CITY AND STATE	ZIP CODE	
OCCUPATION			TELEPHONE ( )	
SOCIAL SECURITY NUMBER			DRIVERS LICENSE #	
NAME OF SPOUSE / PARTNER / FIRST NAME	MIDDLE	LAST NAME	DOB	SOCIAL SECURITY NUMBER
EMPLOYED BY	STREET	CITY AND STATE	ZIP CODE	
OCCUPATION			TELEPHONE ( )	

NOTIFY IN CASE OF EMERGENCY

NAME	TELEPHONE ( )	RELATIONSHIP TO PATIENT

MEDICAL INSURANCE

PRIMARY INS. CO. - NAME OF CARRIER	INSURED NAME	FIRST	MIDDLE	LAST
POLICY / GROUP NO.	ID#	IS POLICY THROUGH EMPLOYER? ☐ YES ☐ NO		
SECONDARY INS. CO. - NAME OF CARRIER.	INSURED NAME	FIRST	MIDDLE	LAST
POLICY / GROUP NO.	ID#	IS POLICY THROUGH EMPLOYER? ☐ YES ☐ NO		

PHARMACY

LOCAL	ADDRESS	TELEPHONE ( )
MAIL ORDER	ADDRESS	TELEPHONE ( )

I hereby authorize Rhonda J. Myers, Ph.D., M.D. to release any and all medical information to the above-named insurance carrier(s) for purposes of clai administration and evaluation, utilization review and financial audit. This authorization remains valid from the date of signing until revoked in writing. I understa that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. Myers all money to which I am entitled medical and/or surgical expense relative to the service rendered by her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood th any money received from the above named insurance company(ies) over and above my indebtedness will be refunded to me when my bill is paid in full. I understa I am financially responsible to Dr. Myers for charges not covered by this assignment. I further agree in the event on non-payment to bear the cost of collectio and/or Court costs and reasonable legal fees should this be required.

Date ____________________

Signature of Responsible Party ____________________