NORTHWEST MEDICAL GROUP
A member of Community Foundation Medical Group and Community Medical Providers

7355 N. PALM AVENUE, #100
FRESNO, CA. 93711
PHONE (559) 271-6302 FAX (559) 271-6327

PATIENT REGISTRATION FORM

Date:_____ Patient/MRN:_____
Primary Care Physician:_____

PATIENT INFORMATION

Patient:_____ SSN:_____ DOB:_____
Marital Status:_____ Employer/School:_____ Sex:_____
Address:_____ City/State:_____ Zip:_____
Phone- Home:_____ Cell:_____ Work:_____

RESPONSIBLE PARTY (only if patient is a Dependent)

Parent/Legal Guardian:_____ SSN:_____ DOB:_____
Relation to Patient:_____ Employer:_____ Sex:_____
Address:_____ City/State:_____ Zip:_____
Phone- Home:_____ Cell:_____ Work:_____

EMERGENCY CONTACT/GUARDIAN

Name:_____ Relation to Patient:_____ Phone:_____
Address:_____ City/State:_____ Zip:_____

INSURANCE INFORMATION-PRIMARY

Company:_____ Employer:_____
Group:_____ ID:_____ Copay:_____
Subscriber:_____ SSN:_____ DOB:_____
Relation to Patient:_____ Phone:_____ Sex:_____
Address:_____ City/State:_____ Zip:_____

INSURANCE INFORMATION-SECONDARY

Company:_____ Employer:_____
Group:_____ ID:_____ Copay:_____
Subscriber:_____ SSN:_____ DOB:_____
Relation to Patient:_____ Phone:_____ Sex:_____
Address:_____ City/State:_____ Zip:_____

This office will bill all HMO and PPO contracted payers- copayments and/or deductibles must be paid at the time of visit.
I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30 day period for all charges whether or not paid by said insurances. I hereby authorize said insurances to release information necessary to secure payment.

Signature:_____ Date:_____