# DEL MONTE, JOHN D.P.M.

Welcome to our office! We are committed to providing the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent.

## PATIENT REGISTRATION FORM

| PATIENT'S ACCOUNT # | GUARANTOR | PCP | CATEGORY |
|---|---|---|---|
| | | | |

| NAME (LAST, FIRST INIT.) | HOME PHONE NO. ( ) - | DOB | DR. LIC# |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| ** DRUG &/OR FOOD ALLERGIES | SOCIAL SECURITY NO. - - | SEX (M/F) | MARITAL STATUS |
|---|---|---|---|
| | | | |

| EMPLOYER | EMPLOYER PHONE ( ) - X |
|---|---|
| | |

| EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO. |
|---|
| |

**INSURANCE INFO.**
PLEASE PROVIDE COPY OF INSURANCE CARD

| INSURANCE NAME & ADDRESS |
|---|
| |

| SUBSCRIBER NO. | GROUP NO. | COVERAGE FROM | COVERAGE TO |
|---|---|---|---|
| | | | |

| ANNUAL DEDUCTIBLE | DEDUCTIBLE MET | CO-PAYMENT | % OF COVERAGE | PAY PLAN |
|---|---|---|---|---|
| | | | | |

| CLAIM NUMBER | INSURED'S NAME | INSURED'S DATE OF BIRTH |
|---|---|---|
| | | |

| INSURED'S SEX (M/F) | INSURED'S PHONE NO. | INSURED'S SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| INSURED'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| INSURED'S EMPLOYER | EMPLOYER'S PHONE NO. |
|---|---|
| | |

| EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

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|---|---|---|---|
| | | | |

| ANNUAL DEDUCTIBLE | DEDUCTIBLE MET | CO-PAYMENT | % OF COVERAGE | PAY PLAN |
|---|---|---|---|---|
| | | | | |

| CLAIM NUMBER | INSURED'S NAME | INSURED'S DATE OF BIRTH |
|---|---|---|
| | | |

| INSURED'S SEX (M/F) | INSURED'S PHONE NO. | INSURED'S SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| INSURED'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| INSURED'S EMPLOYER | EMPLOYER'S PHONE NO. |
|---|---|
| | |

| EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at time of visit, and any costs not a benefit of your plan. If you do not have insurance we would appreciate payment at the time of your visit. Our staff is available if you have any questions.
I authorize payment of medical benefits be made directly to the physician provider for services rendered.
I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

DATE

PATIENT SIGNATURE