

Registration Information

Saviors Medical Group

246 E Scott St
Port Hueneme, CA 93041
Phone: 805-271-0708
Fax: 805-271-0769

Welcome to Our Practice

Date _____ Home Phone _____

Patient _____
Last Name _____ First Name _____

Responsible Party (if patient is a minor) _____

Street Address _____

City _____ State _____ Zip _____ Sex M F Age _____

Birth Date _____ Single Married Divorced

Social Security # _____ Spouses Social Security # _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse Employed By _____

Business Address _____

Occupation _____ Business Phone _____

With whom may we share information about your account? Name _____
Relationship _____ Phone _____

With whom may we share your medical records? Name _____
Relationship _____ Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? _____

Name of Policy Holder _____

Name of Insurance Company _____

Policy # _____ Group # _____ Subscriber # _____

Name of Secondary Insurance Company (if any) _____

Policy # _____ Group # _____ Subscriber # _____

Medicare # _____ Medicaid # _____

How were you referred to our practice? _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy practices.

Signature: _____ Date: _____