MARK A. GREENFIELD, D.O., P.C.
PATIENT REGISTRATION FORM

Patient Name: ______________________ Birthdate: ______________ Age: ________

Mailing Address: ____
(Include apt#) (City) (State) (Zip)

Permanent Address: ____
(If different from above)

Home Phone ( ) ____________ Work Phone ( ) ____________ Cell ( ) ____________

May we leave a message on your home phone? _____ Work phone? ________ Cell phone? ____________

Social Security No. ______________ Is Patient: Employed Full Time Student Part time Student

Ethnicity: White / Hispanic / Other/Unknown Race: White /African American /Asian /Amer.Indian /Other /Unknown

Primary language spoken at home: ________________

Responsible Party: ________________ Relationship to Responsible Party: Spouse / Parent / Other

Who, besides yourself, may we speak with regarding your health care? ________________

Patient's Employer: ____

Employer Phone #: ____

Was this injury related to an accident: Y N (If "Yes", please indicate either: AUTO or JOB)

Date of Injury/First Symptoms: ____

**Please describe what you are being seen for: ____

Nearest Relative or Spouse Information: ____

Referred by: ________________ Primary Care Dr.: ________________

*********************************INSURANCE INFORMATION************************************

PRIMARY / INDUSTRIAL INSURANCE INFORMATION

Insurance Co. Name: ________________

Claims Address: ________________

Phone: ( ) ________________

Policyholder: ____________ Relationship: ________

Date of birth: ________ Employer: ____________

Policy#/ID# ________________

SECONDARY INSURANCE/ATTORNEY INFORMATION

INS/Attorney Name: ________________

Address: ________________

Phone: ( ) ________________

Policyholder: ____________ Relationship: ________

Date of birth: ________ Employer: ____________

Policy#/ ID# ________________

PAYMENT AUTHORIZATION: I hereby authorize payment directly to Mark A. Greenfield, D.O., P.C., 4344 W. Bell Rd, Glendale, AZ 85308, for the medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by insurance. I acknowledge that if I have health insurance coverage, my health insurance may include a provision for billing other sources of payment for my total bill. GENERAL INFORMATION: Tape or video recordings are strictly prohibited unless advance, written permission is received from the physician. This office will maintain your medical records for six (6) years from the date of your last visit.

Patient/Parent/Guardian Signature: ______________________________ Date: ____________