Saman B. Chubineh, M.D.

REGISTRATION FORM

Please answer all questions in full

Today's Date:	**Primary Care Physician:**			
PATIENT INFORMATION				
Patient's last name: First:		Middle:	Salutation:	Marital status:
Is this your legal name?	If not, what is your legal name?	Birth date:	Age:	Sex:
Address:	City:		Zip code	
Home phone no.:	Cell phone no.:	E-mail Address:		
Occupation:	Ethnicity/Race	Preferred Language		
Social Security Number:	Referring Physician:			
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:	
Occupation:	Employer:	Employer address:	Employer phone no.:	
Please indicate primary insurance:				
Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
IN CASE OF EMERGENCY				
Name of Emergency Contact:	Relationship to patient:	Home phone no.:	Work phone no.:	
Address of Emergency Contact:				

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Saman B. Chubineh, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date