

Registration

Thank you for choosing **Dr. Daniel J. Para, MD.** In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date _____ Patient Name _____ Birthdate _____
SSN _____ Male Female Cell Phone _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient s or Parent s Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent s Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring **You?** _____ Primary Physician _____
Emergency Contact _____ Phone _____

Responsible Party

Name of Person Responsible _____ Relationship _____
Address _____ Home Phone _____
Drivers License # _____ Birthdate _____ SSN _____
Employer _____ Work Phone _____
Is this person currently a patient at our office? Yes No

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____
Name of Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ ID # _____ Group # _____
Phone _____

Do you have any additional insurance? Yes No **If yes, please complete the following:**

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____
Name of Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ ID # _____ Group # _____
Phone _____

I authorize release of any information concerning my (or my child s) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of Patient, Parent and/or Legal Guardian

Date