



**TAHOE FOREST
MULTISPECIALTY CLINICS**
A Service of Tahoe Forest Health System

PO Box 759, Truckee, CA 96160

PATIENT REGISTRATION

PATIENT
NAME _____ GENDER M F WHERE DID YOU HEAR OF US? _____

DATE OF BIRTH _____ SS# _____ DRIVERS LICENSE # _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____ Email Address: _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

HOME PH (_____) _____ - _____ WORK PH (_____) _____ - _____ CELL PH (_____) _____ - _____

EMPLOYED? YES NO PREFERRED PHARMACY: _____

EMPLOYER'S NAME _____ EMPLOYER'S PHONE (_____) _____ - _____

MARRIED? YES NO RELIGIOUS PREFERENCE: _____ PRIMARY CARE PHYSICIAN: _____

SPOUSE'S NAME _____ SPOUSE'S SS# _____ SPOUSE'S DATE OF BIRTH _____

MAY WE LEAVE A MESSAGE ON YOUR HOME PHONE REGARDING YOUR CARE? YES / NO

PRIMARY INSURANCE COMPANY _____

ARE YOU THE POLICY HOLDER? YES NO COPAY\$ _____ DEDUCTIBLE\$ _____

•If you are not the policyholder on your primary insurance please provide the following information:

POLICY HOLDER'S NAME _____ BIRTHDATE _____

SS# _____ PHONE (_____) _____ - _____

MAILING ADDRESS _____

RELATIONSHIP TO YOU _____ EMPLOYER _____

SECONDARY INSURANCE COMPANY _____

ARE YOU THE POLICY HOLDER? YES NO

•If you are not the policyholder on your secondary insurance please provide the following information:

POLICY HOLDER'S NAME _____ BIRTHDATE _____

SS# _____ PHONE (_____) _____ - _____

MAILING ADDRESS _____

RELATIONSHIP TO YOU _____ EMPLOYER _____

EMERGENCY CONTACT _____ PHONE (_____) _____ - _____

ADDRESS _____ RELATIONSHIP _____

WE REQUIRE THAT YOU PRESENT YOUR INSURANCE CARD(S) FOR PHOTOCOPYING. IF YOU DO NOT HAVE YOUR INSURANCE CARD(S) YOU WILL BE BILLED FOR ALL SERVICES PROVIDED UNTIL SUCH TIME AS WE RECEIVE A VALID INSURANCE CARD.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO Tahoe Forest MultiSpecialty Clinics and their representatives by my insurance company or other entity responsible for payment of my medical claims. I understand and acknowledge that this assignment in no way releases me from my part of the financial responsibility for services rendered. I further understand and acknowledge that the financial responsibility for services rendered rests with the patient and/or his family regardless of insurance coverage. I further understand and acknowledge that services are to be paid for in full within 30 days by the patient or his/her insurance carrier.

Signature _____ Date _____