

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: _____