Spanish Hills Medical Group
1901 Outlet Center Drive Suite 200
Oxnard, Ca. 93036
Phone (805) 981-8300 Fax (805) 981-8302

PATIENT REGISTRATION FORM

Patient Name_____
Last First Initial

Address_____
City State Zip

Home# _____Cell # _____ Work# _____

Sex: Male ____Female____ DOB: ____/____/____ Social Security #_____

Marital Status: S / M / D / W **Email:**_____

Employer: _____Occupation:_____

Language: _____ Race:_____ Ethnic Group:_____

In case of an emergency who should we notify _____
Name Phone Relationship

Please check PCP: [ ] Victor Alcocer, M.D. [ ] Sergio Neira, M.D. [ ] Jose Pleitez, M.D.

Patient Insurance Information (PRIMARY)

Name of Policy Holder: _____ Date of Birth: _____

SSN# _____ Relationship: _____

Address: _____
City State Zip

Insurance Policy Name :_____

Policy #_____ Group#_____

Patient Insurance Information (SECONDARY)

Name of Policy Holder:_____ Date of Birth:_____

SSN# _____ Relationship:_____

Address:_____
City State Zip

Insurance Policy Name:_____

Policy #_____ Group#_____

Consent to Treat & Assignment and Release of Medical Information

Please read the following completely and sign below where indicated. Services may be withheld if not signed.

I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from **Spanish Hills Medical Group** for insurance claim submission and/or payment for services. I authorize payment of medical benefits to **Spanish Hills Medical Group** for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for procedures and services rendered, and/or any related fees.

I have read the above statement and understand my financial responsibilities.

Signature of Patient: _____ **Date:**_____

Signature of Responsible Party: _____ **Date:**_____
(If other than patient)

Parent / Guardian / *POA _____ **Relationship** _____

Print Name of Responsible Party: _____ **Date:** _____

*** WE MUST HAVE A CURRENT POWER OF ATTORNEY ON FILE***