DARYL R. RHEUARK, M.D., M.S., F.A.C.S.
24520 HAWTHORNE BOULEVARD • SUITE 240 • TORRANCE, CALIFORNIA 90505
(310) 373-8777

PATIENT REGISTRATION

PLEASE COMPLETE ENTIRE FORM

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	FORMER OR MAIDEN NAME

SOCIAL SECURITY NO.	SEX	BIRTHDATE	MARITAL STATUS	DRIVERS LICENSE NO.	PHONE NO.

RESIDENCE STREET ADDRESS	CITY	STATE/ZIP	PAGER NO.

MAILING ADDRESS, IF DIFFERENT	CITY	STATE/ZIP	CELLULAR NO.

EMPLOYER NAME/ADDRESS	CITY	STATE/ZIP	PHONE NO. / EXT.

REFERRING PHYSICIAN'S NAME ADDRESS	CITY	STATE/ZIP	PHYSICIAN'S PHONE NO.

PLEASE COMPLETE IF PATIENT IS A MINOR

MOTHER'S NAME	WORK PHONE	HOME PHONE/CELL PHONE

RESIDENCE STREET ADDRESS *(IF DIFFERENT THAN PATIENT)*	CITY	STATE/ZIP

FATHER'S NAME	WORK PHONE	HOME PHONE/CELL PHONE

RESIDENCE STREET ADDRESS *(IF DIFFERENT THAN PATIENT)*	CITY	STATE/ZIP

PERSON TO CONTACT IN CASE OF EMERGENCY *(Nearest Relative or Friend not Living with You)*

LAST NAME	FIRST	M.I.	RELATIONSHIP	HOME PHONE NO.

RESIDENCE STREET ADDRESS	CITY	STATE/ZIP	BUSINESS PHONE NO.	PAGER/CELLULAR NO.

PRIMARY INSURANCE

INSURANCE COMPANY	MAILING ADDRESS

IDENTIFICATION/CERTIFICATE NO.	GROUP NO.	PLEASE CHECK ONE
		EMPLOYER SPONSORED PLAN ☐ PRIVATE/SELF PAY PLAN ☐

*** PLEASE COMPLETE IF THE PATIENT IS NOT THE SUBSCRIBER TO INSURANCE ***

SUBSCRIBER'S FULL NAME	RELATION TO PATIENT	BIRTHDATE	SOCIAL SECURITY NO.

EMPLOYER'S NAME	ADDRESS	CITY	STATE/ZIP	PHONE NO. / EXT.

SECONDARY INSURANCE

INSURANCE COMPANY	MAILING ADDRESS

IDENTIFICATION/CERTIFICATE NO.	GROUP NO.	PLEASE CHECK ONE
		EMPLOYER SPONSORED PLAN ☐ PRIVATE/SELF PAY PLAN ☐

*** PLEASE COMPLETE IF THE PATIENT IS NOT THE SUBSCRIBER TO INSURANCE ***

SUBSCRIBER'S FULL NAME	RELATION TO PATIENT	BIRTHDATE	SOCIAL SECURITY NO.

EMPLOYER'S NAME	ADDRESS	CITY	STATE/ZIP	PHONE NO. / EXT.

MINORS: This practice assumes both parents listed have joint legal custody and share the right to make healthcare decisions for their child. That either parent acting alone may consent to a recommended medical treatment and/or procedure. Proof of legal custody must be provided to challenge decisions made by the accompanying parent.

AUTHORIZATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENTS

I authorize any insurance carrier, or Daryl R. Rheuark, M.D. to release any information or medical record which is reasonably necessary to process any claim, or which may have a bearing on benefits payable to any carrier or benefit plan.

I hereby authorize payment by my insurance carrier(s) directly to Daryl R. Rheuark, M.D. and irrevocably assign to Daryl R. Rheuark, M.D. all payments for medical services rendered and all medical benefits. I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs regardless of any insurance claims or coverage. I agree to pay all charges in a timely manner.

I agree that a photocopy of this signed form is as valid as the original.

SIGNATURE _____ DATE _____

PLEASE PRINT NAME _____ RELATION TO PATIENT _____

SOCIAL SECURITY NUMBER OF PATIENT OR GUARDIAN ACCOMPANYING MINOR. IF NOT LISTED ABOVE: _____