REGISTRATION
(PLEASE PRINT)

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Telephone: (559) 435-0220

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for _____ years ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Height_____ Weight_____ Shoe Size_____

Please check any symptoms you are currently having or have had in the past year:

SKIN
[ ] Change in Moles
[ ] Itch
[ ] Keloid
[ ] Rash
[ ] Skin Cancer

HEAD
[ ] Headaches
[ ] Migraines
[ ] Trauma

EYES
[ ] Cataract
[ ] Contact Lenses
[ ] Glasses
[ ] Glaucoma
[ ] Macular Degeneration
[ ] Retinopathy

EARS
[ ] Deafness
[ ] Dizziness
[ ] Hearing Loss
[ ] Ringing

NECK
[ ] Pain [ ] Stiffness
[ ] Swollen Glands

NOSE AND SINUS
[ ] Bleeding
[ ] Sinusitis
[ ] Hay Fever

THROAT
[ ] Hoarseness
[ ] Infection
[ ] Soreness
[ ] Tonsilitis

RESPIRATORY
[ ] Asthma
[ ] Chest Pain
[ ] Cough
[ ] Exposure to Tuberculosis
[ ] Infection
[ ] Wheezing

CARDIAC / VASCULAR
[ ] Angina / Chest Pain
[ ] Fainting
[ ] Murmur
[ ] Palpitations
[ ] Phlebitis / Blood Clot
[ ] Rheumatic Fever
[ ] Short of Breath
[ ] High Blood Pressure

GASTROINTESTINAL
[ ] Acid Reflux
[ ] Blood in Stool
[ ] Constipation
[ ] Diarrhea
[ ] History of Ulcers
[ ] Nausea
[ ] Vomiting

BREAST
[ ] Discharge
[ ] Masses
[ ] Tenderness

HEMATOLOGIC
[ ] Anemia
[ ] Bleeding
[ ] Bruising
[ ] Transfusions

MUSCULOSKELETAL
[ ] Artificial Joints
[ ] Back Pain
[ ] Pain in Joints

EMOTIONAL
[ ] Anxiety
[ ] Depression

Please check any of the following conditions you have or have in the past:

[ ] AIDS
[ ] Arthritis
[ ] Bleeding Disorders
[ ] Cancer
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Heart Disease
[ ] Hepatitis
[ ] Herpes
[ ] High Cholesterol
[ ] HIV Positive
[ ] Kidney Disease
[ ] Liver Disease
[ ] Measles
[ ] Mumps
[ ] Pneumonia
[ ] Prostate Problem
[ ] Scarlet Fever
[ ] Stroke
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Veneral Disease

Name of primary care doctor: _____

Please list any allergies that you may have: _____

List any medications you are currently taking: _____

_____

List any surgeries that you have had: _____

_____

To the best of my knowledge, the above information is correct. I understand that it is my responsiblity to inform Dr. Mullen if there are any changes in health, I also authorize treatment and understand that I am responsible for any charges in the service that I receive.

X _____ X _____

Signature of Patient, Parent or Guardian Date

Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- Your insurance policy is contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verity benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

- You must inform the office of all-insurance changes. In the event the office is not informed, you will be responsible for any charges denied.

- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

- **Copays are due at the time of service.**

Signature:_____ Date:_____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that a copy of the medical practice Notice of Privacy Practice is available to me to read in the reception area.

Signature:_____ Date:_____

Disclosure Statement

Should surgical intervention be necessary during the course of your treatment, you will have the choice of where the procedure will be performed. Dr. Mullen has financial interest in Summit Surgical Center and Fresno Surgery Hospital.

Please feel free to discuss your preference and where you would like your surgery to be performed.

Signature:_____ Date:_____