REGISTRATION
(PLEASE PRINT)

SOUTH ATLANTIC MEDICAL GROUP, Inc.
Main Office: Telephone: (323) 725-0167
Fax: (323) 725-6933
Clinic Location: □ Los Angeles/Commerce □ Huntington Park □ Bell Gardens □ Gardena □ El Monte

Date ____________________________ Home Phone _________________________________

Patient ____
Last Name First Name Initial

Responsible Party (if minor) ____

Street Address ____

City _____________________________________ State ___________________________ Zip____________________

Sex ☐ M ☐ F Age ___________Birthdate ____________________ ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By ____

Occupation ____ Business Phone ______________________________

Spouse (or responsible party) Name _______________________________ Birthdate____________________________________

Business Name and Address ____

Occupation ____

Who is responsible for this account? _______________________________________ Relationship to patient_________________________

Your Social Security # _____________________________ Spouse's Social Security # ____

Do you have Medical Insurance? □ No □ Yes ► If yes,

Name of Primary Insurer ____

Subscriber ID # _______________________________________ Group # _____________________________________

Name of Secondary Insurer (if any) ____

Subscriber ID # _______________________________________ Group # ____

□ Medicare □ Medicaid Claim ID # __________________________________

In case of emergency, who should be notified? _____________________________________Phone__________________________________
(Relative / Friend not living with you)

How did you learn of our practice? ____

ASIGNMNET AND RELEASE
I, the undersigned, have coverage with ____
Name of Insurance Company
and assign directly to Dr. ____ all medical 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 my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. __________________________________
For any services furnished for me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ____
Beneficiary Signature Date