UCLA Health System

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Social Security no.:	Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer: (Name and Address)	Work phone no.: ( )			
Cell Phone No: ( )	E-mail:				
Mailing Address:					
How should we contact you: ❑ Cell Phone ❑E-mail ❑ Home Phone ❑ Work Phone ❑ Mail					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Blue Cross PPO / HMO ❑ Blue Shield PPO	❑ SCAN	❑ Health Net HMO / PPO	❑ Aetna HMO /PPO	❑ PacifiCare HMO / PPO
❑ Secure Horizons	❑ Cigna HMO / PPO	❑ Medicare	❑ *Private Healthcare Systems*	❑ Other:	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Who Referred you to this office:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*