



# LivWell Rheumatology

1505 Soquel Drive Ste #9, Santa Cruz CA 95065

Telephone: 831-462-8960 Fax: 831-462-8969

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## Patient Registration

### Patient Demographics Information

Patient Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
(First) (Last)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F  Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(# and Street) (City, State and Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

### Insurance Information

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Patient's Relationship to Insured: Self  Spouse  Child  Other

### Additional Information and Emergency Contact

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: M  S  D  W  Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize payment of medical benefits to the undersigned physician directly for services rendered in the office. It is customary that payment of initial visit be paid in full at the time of service. Accounts are due in 30 days and may be subject to 10% annual finance charge. I understand that if my insurance requires pre-authorization from my Primary Care Provider, that I will be responsible for obtaining this pre-authorization or sign a waiver, be responsible for the insurance billing, and pay the charges in full on the service date.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_