Roland J Dominguez MD PA

Patient Registration Information

Please PRINT and complete ALL the sections below

Patient's Personal Information

Today's Date: ______________

Name: ______________________ ______________________ ______________
Last Name First Name Middle Name

Date of Birth: ________ / ________ / ________ Age: ________ Sex: ☐ Male ☐ Female

Home Phone: (____) ______________ Child lives with (circle one): Mother / Father / Other ____________

Address: ______________________ Apt.#: ________ City: ______________ State: ______ Zip: ________

Ethnicity (circle one): Hispanic / Not Hispanic Race (circle one): Asian / Black / White / Other Race ____________

Mother's Name: ______________________ DOB: __________

Home Address: ______________________ City: ______________ State: ______ Zip: ________

Employer Name/Address: ____

Phone Number (Home): ______________ Work Phone: ______________ Cell Phone: ______________

Father's Name: ______________________ DOB: __________

Home Address: ______________________ City: ______________ State: ______ Zip: ________

Employer Name/Address: ____

Phone Number (Home): ______________ Work Phone: ______________ Cell Phone: ______________

Martial Status (circle one): Married Single Divorced (If Divorced which parent has legal custody?

Patient's Insurance Information

Please present insurance cards to receptionist

Primary Insurance: ______________________ Group #: ______________ Policy #: ______________

Secondary Insurance: ______________________ Group #: ______________ Policy #: ______________

Additional Children

Name: ______________________________________ Date of Birth: ______________

Name: ______________________________________ Date of Birth: ______________

Name: ______________________________________ Date of Birth: ______________

Emergency Contact

Name: ______________________ Phone #: ______________ Relationship: ______________

Assignment of Benefits•Financial Agreement

I hereby assign, transfer, and set over to Roland J Dominguez MD PA all of my rights, titles, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further authorize the release of private health information to other providers involved in my child's care.

Date: ______________________ Signature: ______________________________