Caryn M. West & Associates, PC

Date: 03/11/2024

Registration Form

Patient Name : _____

Address : _____

City, State, Zip : _____

Date of Birth : _____ Allergies : _____

Sex : [ ] Female [ ] Male Social # : _____

Home Phone Number : _____ Work Phone # : _____

Emergency Contact : _____

Emergency Phone : _____

PRIMARY INSURANCE : _____ Secondary Ins: _____
Please have your insurance card and one other ID available at our front desk

SPOUSE
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Name : _____ SSN : _____

Employer : _____ Work Phone : _____

GUARDIAN / PARENT INFORMATION IF PATIENT IS A MINOR
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	Mother	Father
Name :	_____	_____
SSN :	_____	_____
Home Phone:	_____	_____
Work Phone:	_____	_____

CHECK-OUT NOTE:
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PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept prior to SURGERIES.

RELEASE OF INFORMATIOM and ASSIGNMENTS OF BENEFITS DECLARATION
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I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE, BLUE CROSS/SHIELD Insurance for services rendered. I understand and agree to the above conditions.

_____ _____
Date Signature

NO SHOW POLICY

As a courtesy, please remember to call us as soon as you know that you will be unable to make your scheduled appointment and we will be happy to reschedule it for you. If you miss an appointment or fail to give us 24 hours' notice, a no-show fee of $50 will be billed to your account.

Name_____ Account_____

Signature_____ Date_____