



ROMEIO MEDICAL CLINIC
1801 COLORADO AVE SUITE 120 TURLOCK, CA 95382
TELEPHONE (209) 216-3456 FAX (209) 216-3462

PATIENT REGISTRATION SHEET

PATIENT LAST NAME _____ FIRST NAME _____
ADDRESS _____ CITY _____ STATE _____
ZIP CODE _____ TELEPHONE _____ MOBILE _____
DATE OF BIRTH _____ AGE _____ SEX _____ MARTIALSTATUS _____
SOCIAL SECURITY # _____ E MAIL _____
OCCUPATION _____ EMPLOYER _____
EMPLOYER'S ADDRESS _____ EMPLOYER'S PHONE _____
PREFERRED PHARMACY _____ EMERGENCY CONTACT _____

IF PATIENT IS UNDER 18, RESPONSIBLE PARENT/GUARDIAN

PARENT/GUARDIAN NAME _____ RELATIONSHIP _____
PARENT/GUARDIAN HOME PHONE _____ MOBILE _____

PRIMARY INSURANCE INFORMATION
(PLEASE PROVIDE COPY OF INSURANCE CARD)

INSURANCE COMPANY _____ ID# _____ GROUP# _____
CLAIMS ADDRESS _____ EFF DATE _____
NAME OF INSURED _____ DOB _____ SSN _____
INSURED'S ADDRESS _____ INSURED'S PHONE _____
INSURED'S EMPLOYER _____ EMPLOYER'S PHONE _____
EMPLOYER'S ADDRESS _____

SECONDARY INSURANCE INFORMATION
(PLEASE PROVIDE COPY OF INSURANCE CARD)

INSURANCE COMPANY _____ ID# _____ GROUP# _____
CLAIMS ADDRESS _____ EFF DATE _____
NAME OF INSURED _____ DOB _____ SS# _____
INSURED'S ADDRESS _____ INSURED'S PHONE _____
INSURED'S EMPLOYER _____ EMPLOYER'S PHONE _____
EMPLOYER'S ADDRESS _____

I hereby authorize the release of any medical information to insurance carriers to process a claim and request payment either to myself or to Romeo Medical Clinic for medical services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE.**

SIGNATURE _____ DATE _____