

Sunshine Walk-In Clinic

Patient Registration

Last Name

First Name

Middle Initial

Date of Birth

M / F
Gender

Social Security Number

Marital Status

(Area code) Home Phone Number

(Area code) Work Number

(Area Code) Cell Number

Home Address

City

State

Zip Code

Guarantor Information

Last Name

First Name

Middle Name

Patient's Relationship to Guarantor

Date of Birth

M / F
Gender

Social Security Number

Marital Status

(Area code) Home Phone Number

(Area code) Work Number

(Area Code) Cell Number

Home Address

City

State

Zip Code

Emergency Contact

Name

Relationship to Patient

(Area code) Phone Number

Signature of Patient or Guardian

Payment of Benefits

I assign directly to Sunshine Walk-In Clinic/Dr. Barsoum all payment of the Medical and/or Surgical Benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Insured/Patient/Guarantor

Date

Release of Information

I hereby authorize Physician to release any information acquired in the course of my examination or treatment. (Insurance company or other health care providers)

Signature of Insured/Patient/Guarantor

Date

Sunshine Walk-In Clinic

Primary Insurance Information

Insurance Company Name

Policy Holder

Claim's Address

City, State, Zip Code

Insurance Phone Number

ID#

Group#

Date of Birth

Social Security Number

Patient's Relationship to Insured

Employer

Secondary Insurance Information

Insurance Company Name

Policy Holder

Claim's Address

City, State, Zip Code

Insurance Phone Number

ID#

Group#

Date of Birth

Social Security Number

Patient's Relationship to Insured

Employer

Payment of Benefits

I assign directly to Sunshine Walk-In Clinic/Dr. Barsoum all payment of the Medical and/or Surgical Benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Insured/Patient/Guarantor

Date