Sunshine Medical Care

Patient Registration

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender M / F Social Security Number _____ Marital Status _____

(Area code) Home Phone Number _____ (Area code) Work Number _____ (Area Code) Cell Number _____

Home Address _____ City _____ State _____ Zip Code _____

E-Mail: **(Required)** _____

Guarantor Information

Last Name _____ First Name _____ Middle Name _____ Patient's Relationship to Guarantor _____

Date of Birth _____ Gender M / F Social Security Number _____ Marital Status _____

(Area code) Home Phone Number _____ (Area code) Work Number _____ (Area Code) Cell Number _____

Home Address _____ City _____ State _____ Zip Code _____

How did you hear about us? (IMPORTANT: Please Answer): _____

Emergency Contact

Name _____ Relationship to Patient _____ (Area code) Phone Number _____

Signature of Patient or Guardian _____

Payment of Benefits

I assign directly to Sunshine Medical Care/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 Medical care

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 _____

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Signature of Insured/Patient/Guarantor _____ Date _____