PATIENT REGISTRATION
PLEASE PRINT AND ANSWER ALL QUESTIONS
JOSEPH CHEBLI MD FACS

Marital Status: (Check One) S ☐ M ☐ W ☐ D ☐

Patient: _____ Female ☐ Male ☐
(Full Legal Name) Last First Middle

Patient's Home Address: _____ Apt #_____

City: _____ State: _____ Zip: _____ Home Phone No. ( )_____

E-Mail Address: _____ Cell Phone No. ( ) _____

Birth date: _____/_____/_____ Social Security No. _____-_____-_____

Person Responsible for Bill if Patient is a Minor: _____

Home Address (if different from above): _____ Apt#_____

Patient's Primary Care Physician: _____ Phone No: ( ) _____

*Referred to this office by _____

Patient's Employer: _____ Work Phone No. ( ) _____
(Parent if Minor) *If student name of school or college*

Spouse's Name: _____ Date of Birth: _____/_____/_____

Spouse's Employer: _____ Employer Phone No.: ( ) _____

HEALTH INSURANCE

PRIMARY INSURANCE: _____EFFECTIVE DATE: _____

Policy/ID #_____Group #_____Employer/Group Name_____

Subscriber's Name_____ Date of Birth_____ Relationship to Patient_____

Co-Payment amount: _____

SECONDARY INSURANCE: _____EFFECTIVE DATE: _____

Policy/ID #_____ Group#_____ Employer or Group Name _____

Subscriber's Name_____ Date of Birth_____ Relationship to Patient_____

Other Insurance (Please list on back if necessary) _____

Co-Payment amount: _____

LABOR AND INDUSTRY Claim #_____ Date of Injury_____/_____/_____Time: _____

Employer at time of injury: _____ Accident Location: _____

Injured Area: _____
(When filing an L&I claim you still need to list your Primary Insurance coverage in the section above. If no other coverage, Please indicate by checking no in the box provided.)
NO OTHER COVERAGE: ☐

ASSIGNMENT AND RELEASE: I authorize treatment of the person named above and agree to pay all fees and co-payments for the services not covered by a contracted medical plan. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to Joseph Chebli, MD, FACS where applicable but without his assuming the responsibility for the collection thereof.

SIGNED: _____DATE: _____

Emergency Contact (Not living with you) _____ Relationship _____

Phone No. ( ) _____ Address: _____