



# PATIENT REGISTRATION

## INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize release of any medical information necessary to process any insurance claims with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-insurance/or amounts for services not covered by the insurance carrier. All professional services rendered are charged to the patient. I further authorize release of all pertinent medical records to my physician at Desert Perinatal Associates for continuing medical treatment.

The patient is responsible for all fees regardless of insurance coverage. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the physicians. A copy of signature is as valid as the original.

Signature of Patient or Responsible Party (if minor):

\_\_\_\_\_

- Joseph A. Adashek, M.D., FACOG
- Paul T. Wilkes, M.D., FACOG
- Patricia M. Pierce, M.D., FACOG
- Van R. Bohman, M.D., FACOG
- Joel K. Schwartz, M.D., FACOG
- Alan D. Bolnick, M.D., FACOG
- Quynh T. Vo, M.D., FACOG

### PATIENT'S NAME

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Method of Contact:  Home  Cell  E-mail Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Marital Status \_\_\_\_\_

E-Mail \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

REFERRED BY \_\_\_\_\_

### SPOUSE or RESPONSIBLE PARTY

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone \_\_\_\_\_

### NEAREST PERSON TO CONTACT NOT LIVING WITH YOU

Name of relative NOT living with you _____	Name of friend NOT living with you _____
Relationship _____ Phone Number _____	Relationship _____ Phone Number _____
Address: Street _____	Address: Street _____
City/State/Zip _____	City/State/Zip _____

### INSURANCE INFORMATION

Name of Primary Insurance Carrier \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

9280 W. Sunset Rd., Suite 236  
[Next to Southern Hills Hospital]  
Las Vegas, NV 89148

TEL: 702 341-6610  
FAX: 702 341-6961

653 N. Town Center Dr., Suite 412  
[Next to Summerlin Hospital]  
Las Vegas, NV 89144

3001 W. Horizon Ridge Pkwy  
[Next to St. Rose Siena Hospital]  
Henderson, NV 89052