



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# _____

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[Next to St. Rose Siena Hospital]
Henderson, NV 89052