Phuong T. Nguyen, MD, FACOG
Obstetrics & Gynecology

REGISTRATION FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Refer to clinic by (name of referring physician):					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:			| Other:		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:			| Other:		
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: | Other:					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:	

The above information is true to the best of my knowledge. I authorize Dr. Nguyen to release any and all medical information to the above named insurance carrier for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from date of signing until revoked in writing. I understand that I may request a copy of this authorization. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I further agree, in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees shoud this be required.

Patient/Guardian signature: _____ _____

Print Name of Patient/Guardian: Date:

4585 Stevens Creek Blvd, Ste 110, Santa Clara, CA 210 N. Jackson Ave, Ste 10, San Jose, CA
Phone: (408) 296-2496 Fax: (408) 520-4575 www.southbayob.com