Victor D. Vela, M.D., P.A.
Board Certified • Family Practice

Patient Registration

PATIENT INFORMATION

New or Established Patient (Circle One)

Name: _____ Birthdate: _____ SocSec: _____

Address: _____ City/State: _____ Zip: _____

Day Tel No. _____ Marital Status: S/M/W/D Student Status: FT/PT

Have you been seen at this office before? Y / N *Referred by:* _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Tel. No. _____ Ext: _____

Address: _____ City/ State: _____ Zip: _____

Human Resource Contact: _____

INSURED PERSON/POLICY HOLDER

(If same as patient - leave blank)

Name:** _____ Birthdate**: ___-___-___ Soc Sec#**: ___-___-___

Address: _____ City/ State: _____ Zip: _____

Employer Name: _____ Tel. No. _____ Ext: _____

Human Resource Contact: _____

Primary Health Insurance**: _____

**Indicates information required to file primary insurance claim!

PLEASE NOTE-THIS OFFICE DOES NOT FILE SECONDARY INSURANCE

EMERGENCY CONTACT

Name: _____ Relationship: _____

Tel No#: _____ Alt. Tel. No.#: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of an original.

I hereby authorize Victor D. Vela, M.D., P.A. to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Victor D. Vela, M.D., P.A..

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am responsible for payment of all medical services rendered. Any checks sent to me by my insurance company will be forwarded to Victor D. Vela, M.D., P.A. to apply to my account, should a balance exist.

SIGNATURE: _____ *DATE:* _____

(Patient, Parent Guardian) Please be prepared to provide picture ID, if requested