MARK W. DOUBRAVA M.D.
PATIENT REGISTRATION FORM

LAST NAME:_____FIRST:_____MI:_____
ADDRESS:_____APT#_____CITY_____STATE_____ZIP_____
DATE OF BIRTH: _____/_____/_____SOCIAL SECURITY NUMBER:_____
HOME PHONE (_____) _____-_____CELL PHONE (_____) _____ - _____EXT_____
EMPLOYER:_____OCCUPATION_____
MARITAL STATUS: _____MARRIED _____SINGLE _____MALE _____ FEMALE AGE: _____
REFERRED BY: (DOCTOR'S NAME, FRIEND, ADVERTISEMENT, INSURANCE LIST.)_____
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU:_____PHONE_____
EMAIL:_____*Email will be used for this office and not shared*

INSURED/ RESPONSIBLE PARTY INFORMATION
LAST NAME_____FIRST:_____MI:_____
ADDRESS:_____APT#_____CITY_____STATE_____ZIP_____
DATE OF BIRTH: _____/_____/_____SOCIAL SECURITY NUMBER_____
HOME PHONE (_____) _____-_____ RELATIONSHIP:_____
EMPLOYER_____ WORK PHONE (_____) _____-_____EXT_____

INSURANCE INFORMATION
PRIMARY INSURANCE NAME: _____PHONE NUMBER: _____
ID NUMBER ON CARD: _____ GROUP NUMBER: _____

SECONDARY INSURANCE NAME: _____PHONE NUMBER: _____
POLICYHOLDER'S NAME: _____DATE OF BIRTH: _____/_____/___
EMPLOYER: _____RELATIONSHIP TO INSURED: _____
ID NUMBER ON CARD: _____ SS NUMBER: _____

SIGNATURE IS REQUIRED (PLEASE READ CAREFULLY, SIGN AND DATE BELOW). THIS ENTIRE FORM WILL BE VOID IF MODIFIED.

***AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION THAT IS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT IF AND WHEN IT IS REQUIRED BY MY INSURANCE COMPANY, A REFERRING DOCTOR, OR HOSPITAL.

***AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** IN CONSIDERATION TO THE SERVICES RENDERED, I, THE UNDERSIGNED PATIENT, DO HEREBY IRREVOCABLY ASSIGN AND TRANSFER TO YOU, MY PROVIDER, MARK W. DOUBRAVA, M.D., ALL BENEFITS DUE TO ME WHETHER CONTRACTUAL, STATUTORY, OR COMMON LAW.

***ANY LABORATORY TESTING DONE IN THE OFFICE WILL BE BILLED SEPARATELY BY THE LAB.**

***I CONSENT TO ANY MEDICAL TREATMENT DEEMED MEDICALLY NECESSARY BY THE PHYSICIAN.**

***PURSUANT TO NRS 629 MY HEALTH CARE RECORDS MAY BE DESTROYED AFTER 5 YEARS.**

***I UNDERSTAND THAT DR. DOUBRAVA WILL BILL MY INSURANCE AS A COURTESY TO ME.** IT IS MY RESPONSIBILITY TO PROVIDE MY CURRENT INSURANCE INFORMATION; INCLUDING A COPY OF MY CARD, IN ORDER THAT MY CARE MAY BE BILLED CORRECTLY. IF PAYMENT IS NOT RECEIVED WITHIN 90 DAYS FROM THE DATE OF BILLING, I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES RENDERED. IF MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, A 40% FEE OF THE OVERDUE BALANCE WILL BE ACCRUED. I AGREE TO PAY ALL COLLECTION AND LEGAL FEES NECESSARY TO CLEAR THE ACCRUED BALANCE ON MY ACCOUNT.

***FAILURE TO CALL POLICY:** IF I MISS MY APPOINTMENT OR IF I FAIL TO CALL TO RE-SCHEDULE OR CANCEL AT LEAST 24 HOURS BEFORE MY SCHEDULED TIME, I WILL BE CHARGED A FEE OF $25.00.

***THERE IS A $25 FEE FOR ANY RETURNED CHECKS.**

Patient Signature:_____Date:_____