



Dr. Hector Diaz, MD

PATIENT REGISTRATION

PATIENT NAME _____
Last First Initial

HOW DID YOU HEAR ABOUT US? _____

Home Address _____

City _____ State _____ Zip _____ Date of Birth _____

Mailing Address (if different) _____

Male/Female _____ Social Security Number _____ Marital Status _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ Telephone _____

Friend or Relative not living With You:

Name _____ Relationship _____

Address _____ Telephone _____

Medical Insurance Information:

Primary Insurance _____ Policy Holder _____

DOB: _____ SSN#: _____

2. Secondary Insurance _____ Policy Holder _____

Name of Spouse or (if a minor) parent _____

Spouse's/Parent's Employer _____ Telephone _____

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to Superior Medical Clinic, LLC dba Genesis Medical Clinic all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Superior Medical Clinic, LLC dba Genesis Medical Clinic to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Superior Medical Clinic, LLC dba Genesis Medical Clinic which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Superior Medical Clinic, LLC dba Genesis Medical Clinic in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature _____ Date _____ Signature (WITNESS) _____ Date _____