Cleo Baruiz, MD PA

Patient Registration

Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____

Previous Last Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female

Home Phone: _____ Mobile Phone: _____

Work Phone: _____

Contact Preference: ☐ home ☐ work ☐ mobile ☐ mail ☐ patient portal on web

Marital Status: ☐ married ☐ single ☐ divorced ☐ separated ☐ widowed

Birth Date: _____

SSN: _____

email: _____

Primary Insurance: _____ Please show card to our staff.

Secondary Insurance: _____ Please show card to our staff.

Language : ☐ English ☐ Other _____

Race: ☐ American Indian ☐ Asian ☐ Asian Indian ☐ Black or African

☐ European ☐ Filipino ☐ Japanese ☐ Korean ☐ White

☐ Native Hawaiian or other pacific islander ☐ other _____

Ethnicity: ☐ Central American ☐ Cuban ☐ Dominican ☐ Hispanic or Latino/Spanish

☐ Latin American/Latin, Latino ☐ Mexican ☐ Not Hispanic or Latino

☐ Puerto Rican ☐ South American ☐ Spaniard

Can non-medical messages be left on: ☐ home voice mail ☐ work voice mail ☐ cell voice mail

☐ Other Person, Name _____

Phone:_____

How did you hear about us? _____

What is your pharmacy name and location? _____

What is your pharmacy telephone number? _____

OK to leave automated voice messages for appointment reminders, annoucements, etc? ☐

OK to send automated email messages for appointment reminders, announcements, etc? ☐

Emergency Contact Name _____ Phone _____

I have read the Notice of Privacy Policy which is posted on the web site www.CleoBaruizMD.com and also available in the office.

Patient Signature: _____ Date: _____

I have read the Notice of Financial Policy which is posted on the web site www.CleoBaruizMD.com and also available in the office.

Patient Signature: _____ Date: _____

I give my permission for Cleo Baruiz MD PA to obtain my medication history from pharmacies that I have used in the past, to enable automatic updates in my electronic medical record.

Patient Signature: _____ Date: _____

Assignment and Release: I assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directory for recommended services performed that are not covered under the terms of my health plan. I authorize Cleo Baruiz MD to release any medical information required to process my claims.

Patient Signature: _____ Date: _____