

Account # For internal use	Farhouch Berdjis, MD Medical Corp 1010 W. La Veta #575 Orange, CA 92868 Telephone: 714-547-0900 Fax: 714-547-2080	
DATE	REGISTRATION FORM	

Primary Physician: _____ Phone #: () _____

Address: _____ Fax # () _____

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MI	DOB	SS #	TELEPHONE #
HOME ADDRESS	CITY	STATE	ZIP	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

PARENTS INFORMATION

MOTHER

Last Name _____ First Name: _____ MI _____ DOB _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Work Phone #: () _____ Cell #: () _____

SS #: _____ Employer: _____

FATHER

Last Name _____ First Name: _____ MI _____ DOB _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Work Phone #: () _____ Cell #: () _____

SS #: _____ Employer: _____

HEALTH PLAN INFORMATION

Primary insurance: _____ Secondary Insurance: _____

Policy # _____ Grp #: _____ Policy # _____ Grp #: _____

Insurance Address: _____ City _____ Insurance Address _____ City _____

State: _____ Zip _____ Phone # () _____ State: _____ Zip _____ Phone # () _____

Medical Group _____ Eff. Date _____ Medical Group _____ Eff. Date _____

Auth. # _____ Phone # () _____ Auth. # _____ Phone # () _____

Subscriber's name _____ Subscriber's name _____

ASSIGNMENT OF BENEFITS

I hereby direct payment to FBMC, of any medical benefits payable to me for the services provided at FBMC. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to the appointment. I will be responsible for the unpaid balance due any bills if this is not done.

X _____
 Patient Signature or Signature of Guardian or Parent Date