Hrachya Paruyryan, MD, Inc.
Diplomate, American Board of Family Medicine

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Print Form

Patient Registration

Referral Source: 1

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL QUESTIONS COMPLETELY.

Patient Information

Patient's Last Name _____ First Name _____ Initial _____
Home Address _____ City _____ State _____ Zip _____
DOB _____ Age _____ Birth Place _____ Race _____ Gender ? ☐ Male ☐ Female
Ethnicity? ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient Declined Social Security No. _____
Driver's License #/ID: _____ *(Provide Copy of Card)* Marital Status 0 _____
E-mail _____ Consent to use? ☐ Yes ☐ No Preferred Language: _____
Home Phone _____ Work Phone _____ Ext. _____ Cell Phone _____
Is patient a student? ☐Yes ☐No If yes: ☐PT ☐FT Provide school name & address: _____
Emergency contact Name ? _____ Relationship ? _____ Phone _____

Responsible Person Information

☐ If Same as Patient, Please Skip This Section Relationship to Patient ? _____
Last Name _____ First Name _____ Initial _____
Home Address _____ City _____ State _____ Zip _____
DOB _____ Social Security No. _____ Gender ? ☐ Male ☐ Female
Home Phone _____ Cell _____
E-mail _____ Consent to use ? ☐ Yes ☐ No

Employer Information

Employer Name _____ Phone _____
Employer Address _____ City _____ State _____ Zip _____

Pharmacy Information

Pharmacy _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

Primary Medical Insurance Information *- Please Complete OR Provide Copy of Current Insurance Card*

☐ If NO Medical Insurance, Please Skip Insurance Sections Employer Name _____
Insured Last Name _____ First Name _____ Initial _____
Relationship: _____ DOB _____ Social Security No. _____
Insurance Name _____ Phone _____
Insurance Address _____ City _____ State _____ Zip _____
Subscriber ID _____ Group Number _____

Secondary Medical Insurance Information *- Please Complete OR Provide Copy of Current Insurance Card*

☐ If NO Medical Secondary, Please Skip This Section Employer Name _____
Insured Last Name _____ First Name _____ Initial _____
Relationship: _____ DOB _____ Social Security No. _____
Insurance Name _____ Phone _____
Insurance Address _____ City _____ State _____ Zip _____
Subscriber ID _____ Group Number _____

AUTHORIZATION

I hereby authorize the practice to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the practice for any services rendered that are not paid for directly by me.

Responsible Person Signature _____ Date: _____

I acknowledge that I have received a copy of the "HIPAA - Notice of Privacy Practices".

Responsible Person Signature _____ Date: _____

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