Metro Comprehensive Medical Center
444 W C Street Suite #185, San Diego, CA, 92101
Phone: (619) 232-6262

Patient Registration

Last Name: ___________________________ **First Name:** __________________________ **M.I.:** ____________________

Social Security #: ______-____-________ **Date of Birth:** ____/____/______ **Sex: Male / Female**

Address: ___________________________________ **City:** ______________________ **ST:** ____ **Zip Code:** _____________

Primary #: (______) ______-________ **Secondary #:** (______) ______-________ **Email:** ___________________________

Emergency Contact: __________________________ **Relation:** _______________ **Contact #:** (______) ______-________

Preferred Language: ________________ **Race/Ethnicity:** _________________ **Sexual Orientation:** __________________

Occupation: ___________________________________ **Employer:** ____

Address: ___________________________________ **City:** ______________________ **ST:** ____ **Zip Code:** _____________

Insurance Information:

Please select one: Private Insurance/ Medicare/ No Insurance **Insurance Company:** ________________________

Policy Holder: ________________________________ **Relation:** ___________________________ **DOB:** ____/____/______

Insurance Address: _______________________________ **City:** __________________ **ST:** ____ **Zip Code:** _____________

Subscriber ID #: _____________________________________ **Group #:** ____

Secondary Insurance Information: ☐ Check if none

Please select one: Private Insurance/ Medicare/ No Insurance **Insurance Company:** ________________________

Policy Holder: ________________________________ **Relation:** ___________________________ **DOB:** ____/____/______

Insurance Address: _______________________________ **City:** __________________ **ST:** ____ **Zip Code:** _____________

Subscriber ID #: _____________________________________ **Group #:** ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that his office will prepare any necessary reports and forms (as a courtesy) to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Metro Comprehensive Medical Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered will be immediately due and payable. I agree that a photocopy of this authorization shall be valid as the original.

Patient or Guardian Signature: ____ **Date:** ____/____/______