SkyPark Preferred Family Care
Thomas W. LaGrelius, MD
Nicole Z. Lawrence, MD
Jeffrey M. Karns, MD

23451 Madison St #140
Torrance, Ca 90505
310-378-6208

New Patient Registration Form

(PLEASE PRINT CLEARLY AND FILL OUT COMPLETLEY)

Full Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Email: _____@_____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: M S D W Sex: M F Referred By: _____

Emergency Contacts:

(1) Name: _____ Relation: _____

Phone Number: _____ Address: _____

(2) Name: _____ Relation: _____

Phone: _____ Address: _____

Billing Address (if different than above):

Street Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Information:

Full Name: _____SSN: _____Date of Birth: _____

Address: _____

Insurance Information

Primary Insurance:

Name: _____

ID #: _____ Group #: _____

Insured Name: _____

Insured Date of Birth: _____

Provider phone number:_____

Secondary Insurance:

Name: _____

ID #: _____ Group #: _____

Insured Name: _____

Insured Date of Birth: _____

Provider Phone number:_____

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Pharmacy Information:

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City, State, Zip: _____

Please Answer the Following Questions

1. Can confidential messages be left on your answering machine or voicemail? Y or N
2. Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment arrangements:

   Name: _____ Relation: _____

   Phone Number: _____ or Email _____

   Name: _____ Relation: _____

   Phone Number: _____ or Email _____

Assignment of Benefits

I assign all insurance benefits to Dr. Thomas W. LaGrelius and/or Dr. Nicole Z. Lawrence and/or Jeffrey M. Karns. I understand that I am financially responsible for all charges whether or not paid by my health insurance. I understand that SkyPark Preferred Family Care is not responsible for knowing my plan, what it will pay for or the deductible requirements. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment and insurance billing.