SkyPark Preferred Family Care
Thomas W. LaGrelius, MD
Nicole Z. Lawrence, 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 Contact: ______________________________ Best Phone Number: __________________________

Billing Address (if different than above)

Street Address: ____

City: ______________________________ State: ________________ Zip Code: ______________________

Responsible Party Information

Full Name: ____ SSN: __________________________

Date of Birth: _______________________ Age: _____ Email: _____________________________________

Home Phone: ___________________________________ Cell Phone: _________________________________

Street Address: ____

City: ______________________________ State: ________________ Zip Code: ______________________

Insurance Information

Primary Insurance

Name: ____________________________________

ID #: ___________________ Group #: ____________

Insured Name: ______________________________

Insured Date of Birth: ________________________

Secondary Insurance

Name: ____________________________________

ID #: ___________________ Group #: ________________

Insured Name: ______________________________

Insured Date of Birth: ________________________

Turn Over for Second Page

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: ________________________________ Best Phone Number: ____________________________

   Name: ________________________________ Best Phone Number: ____________________________

Assignment of Benefits

I assign all insurance benefits to Dr. Thomas W. LaGrelius and/or Dr. Nicole Z. Lawrence. 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.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices information. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature: ____ Date: ______________________
Patient/Responsible Party

Print Name: ____

If not signed by the patient, please indicate:

Relationship: ____