



Bonita Quiroz Cantu
Advanced Registered Nurse Practitioner

Patient Registration Form, DX Codes	
Patient information	
Patient Name:	
Sex:	M { } F { }
Street Address:	
City:	
State:	
Zip Code:	
Home Phone:	
Work Phone:	
Email Address:	
Social Security #:	
Date of Birth:	
Employer:	
Occupation:	
Name of Spouse/partner (if applicable):	
Emergency contact person:	
Phone:	
PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)	
Billing Street Address:	
City:	
State:	
Zip Code:	
Home Phone #:	
Work Phone #:	
Cell Phone #:	
Relationship to patient:	
Employer:	
SS #:	



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Insurance information	
Please provide a photocopy of your insurance card	
Name of Insurance Company:	
Address of Insurance Company:	
Subscriber:	
Relationship to patient:	
Group #:	
ID #:	
Is this a managed care plan?	YES { } NO { }
Have you obtained authorization?	YES { } NO { }
Name of Managed Care Company:	
Phone #:	
Do you have a referral from your primary physician?	YES { } NO { }
Name of primary physician:	
Phone #:	
Referral source	
Name of person referring you to this office:	
<p><i>I, _____ (please print name here)</i> <i>have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and responsibilities as outlined in the above-mentioned handout.</i></p>	
Patient and/or Guardian Signature:	