NEW PATIENT REGISTRATION FORM

Patient Name: _____ Male_____ Female_____

Primary Care Doctor (PCP): _____ Pharmacy name:_____

Pharmacy address: _____ Registration number:_____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Patient's SS#_____ **Patient's Birthday:** _____

Cell: _____ **Email Address**: _____

Referred by: _____ Referring Physician: _____

Responsible party for patient: _____ Relationship: _____

Emergency Contact: _____ Telephone: _____

Primary Insurance: _____ Address: _____

Subscriber/Policyholder: _____ **Subscriber SS#:**_____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Home address: _____Employer:_____

Telephone: _____ Cell: _____

Patient agrees & acknowledges that he/ she is responsible for all attorney fees and costs incurred by Penn Medicine, Dr. Kirkland N. Lozada should any type of legal action be required to collect any unpaid balances by patient and/ or the retention of an attorney by Penn Medicine, Dr. Kirkland N. Lozada be required.

I authorize Kirkland N. Lozada MD, to furnish information to my insurance carrier(s) concerning my illness(es) and treatment. I hereby assign all insurance payments to Kirkland N. Lozada, MD C/O Penn Medicine, Dr. Kirkland N. Lozada and agree to accept full responsibility for all charges for medical services provided to myself and/or any dependents that may not be covered by insurance. WITHOUT EXCEPTION, any charges for any medical services that are not covered by insurance are the full responsibility of the patient, or the responsible party who has signed for this patient.

SIGNATURE: _____ Date: _____

(If patient is a minor, relationship of person signed) _____