Jack E. Padour, M.D.

148 N. Brent St. Suite 201
Ventura, CA 93003
P: (805) 641-1800
F: (805) 653-7468

PATIENT REGISTRATION FORM

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ______

Male_____ Female_____ Date of Birth: _________________ Social Security#: ____________________________

Address: ______________________________________ City: ___________________ State: _____ Zip: _________

Home Phone: ________________________________ Mobile Phone: ____________________________________

Marital Status (circle one): Single Married Divorced Widowed

Name of Spouse: _________________________________ Phone Number: _______________________________

Pharmacy Name: ______________________________________ Phone: __________________________________

Place of Employment: _________________________________ Phone: __________________________________

Nearest Relative or Person we may contact in case of an Emergency
(Outside of your home)

Name: _______________________________________ Relationship: ____________________________________

Address: ____ Telephone #: ____________________________

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Jack E. Padour, M.D. for services rendered by Dr. Padour, in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: ____

SIGNATURE: ____ DATE: _________________________

INSURANCE

Name: ____

Date of Birth: ____________________________

Primary Insurance: ____

ID #:______________________________________ Group #: ____

Secondary Insurance: ____

ID #:______________________________________ Group #: ____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Jack E. Padour, MD for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine benefits payable for these or related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under the Title XVII of the Social Security Act.

COMMERCIAL INSURANCE: I hereby authorize payment of benefits directly to the attending physician. I understand I am financially responsible for the charges not covered by insurance payments. I hereby authorize the attending physician to release any information acquired in the course of my examination and treatment to permit processing of claims for insurance reimbursement.

Although an insurance claim is filed, the patient is ultimately responsible for payment of the account.

A photocopy of this signature is valid as the original.

PRINT PATIENT NAME: ____

SIGNATURE:____DATE: _______________________________

PATIENT QUESTIONNAIRE

Do you have an Advanced Directive: (*please circle one*)

Yes No

Race: (*please circle one*)

American Indian African American Alaskan Native Asian

Native Hawaiian/Pacific Islander White Decline to report/Unreported

Ethnicity: (*please circle one*)

Hispanic/ Latino Non-Hispanic/Non- Latino Decline to report/ Unreported

Primary Language: _______________________ Decline to report: _____________________

SOCIAL HISTORY

Alcohol Use: (*please circle one*)

Yes or No If yes, how many drinks per day: _______ Per week: _______

If quit, what year: ________

Tobacco Use: (*please circle one*)

Yes or No If yes, how many per day: _______

If quit, what year: _______

Illegal Drug Use: (*please circle one*)

Yes or No If yes, how often: ________

If quit, what year: ________

Caffeine Use: *(please circle one*)

Yes or No If yes, how many per day: _________ Per week: _______

AUTHORIZATION FOR NOTIFICATIONS

I, ____ authorize the office of Jack E. Padour, MD to:

Send text notifications to the mobile phone number listed: (*please circle one*)

Yes or **No**

Mobile Phone: (________) ________-_____________

Send notifications to your email address listed: (*please circle one*)

Yes or **No**

Email:____@_______________________________________

Would you like access to the Patient Portal to view your visit notes & lab results? (***please circle one***)

Yes or **No**

Please let us know if you would like more information on the Patient Portal!

PRINT PATIENT NAME: ____

SIGNATURE: ____ DATE: _________________________