David S. Shields, M.D.
Gastroenterology | 650-324-1020

NEW/UPDATE PATIENT REGISTRATION INFORMATION
David Shields, M.D.

Date:________________

Patient's Name: ____
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. (Last) (First) (MI)

Address: ____
(Street) (City) (State) (Zip)

Date of Birth: __________Age: _____Sex: ____ SS#: ____________________ Email Address: ____________________

Day Phone: ____________________Evening Phone: ______________________Cell Phone: _______________
(Area Code) (Area code) (Area Code)

Referred by: _______________________ **Reason for Referral**: ___________________________________

Employed By: ____Phone: _____________________
(Area code)

Work Address: ____
(Street) (City) (State) (Zip)

Spouse/Partner/Parent Name: ______________________________ Phone: ___________________________
(Area code)

Address If Different: ____
(Street) (City) (State) (Zip)

Emergency Contact: ____________________ Relationship: ____________Phone:______________________
(Area code)

Address: ____Phone: ____________________
(Area code)

Name of Insured or Responsible Party for payment, if Different: _______________________________________

Release of Insurance Information:

I hereby authorize Dr. Shields office to furnish the insurance company (s) on file, medical information when requested, and for chart audits by the Insurance Co.

Medicare Patients:

I request that payment of authorized Medicare Benefits either to me or to the participating physicians for any services furnished to me by those physicians. I authorize any holder of medical information about my care to release to Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

____ ____

Signature Date Signature Date

I, (Subscriber, Spouse, Dependent, Legal Guardian) am an eligible member of the Insurance Company on file as of this date of service. Signature of subscriber or responsible party below acknowledges full financial responsibility for services rendered if the patient is determined as "Not Eligible" or if proper authorization has not been completed or provided under membership provisions.

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(Signature of Patient/Guardian/Subscriber) Date