



Raymond M. Seballos, MD, Inc.

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Patient Registration

Patient Name _____ Male Female Birth Date: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate address for mailing (optional): _____

Home Phone: _____ Work Phone: _____ Social Security # _____ - _____ - _____

Employer/School _____ Occupation _____

Marital Status: Single Married Divorced Widowed For minors only: child lives with both parents mother father

May we leave a message at your home with other residents? Yes No On your answering machine/voice mail? Yes No

E-mail address _____ Can we communicate with you via the Internet? Yes No

Other Physician: _____ May we provide him/her with update information Yes No

Who may we talk to about your medical concerns: _____

Is this contact only for emergency purposes only? Yes No, if not can we communicate on your behalf: Yes No

Relationship: _____ Phone # _____

Mother/Guardian: _____ Address (if different) _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Father: _____ Address (if different) _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Responsible party for insurance and bills: Patient Spouse Parents Mother Father Other

Responsible party Date of birth: _____ Employer: _____ Phone # _____

Obtain copy of Driver's license Yes No

Primary Insurance Company: _____ Name on contract: _____

Address: _____ Group # _____ ID # _____

PATIENT'S Relationship to cardholder: Self Spouse Dependent Card Copied: Yes No Co-payment; \$ _____

Secondary Insurance Company _____ Name on Contract: _____

Address: _____ Group # _____ ID # _____

PATIENT'S Relationship to cardholder: Self Spouse Dependent Card copied: Yes No

Identification of other physicians/health care entities involved with my medical care that I authorize ongoing release of information for continuity of care:

Referring Doctor: _____ Phone: _____

Address: _____ Zip: _____

Type of physician/ health care provided: _____

Family Doctor: _____ Phone: _____

Address: _____ Zip: _____

Type of physician/ health care provided: _____

Information reviewed (initial): ____/10____/11____/12____/13____/14____/15____/16____/17____/18____/19____/20____/21