



**Michael P. Stevens, M.D.**

**Bryan D. Gescuk, M.D.**

101 S. San Mateo Dr., #307, San Mateo, CA 94401

Phone (650) 348 - 6011 Fax (650) 348 - 6027

### PATIENT REGISTRATION FORM

#### PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Preferred? \_\_\_\_\_

How would you like appointment reminders? Phone Call Or Text Message

Employer \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Your Primary Care Doctor \_\_\_\_\_

Referred by \_\_\_\_\_

#### Billing Information—Guarantor (if different from above)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

#### Insurance Information

Please bring your insurance card with you to your first appointment. If you have an HMO, make sure you have a referral for this visit. (We do not belong to Brown and Toland Medical Group)

I authorize San Mateo Rheumatology to release any information required in the course of examination or treatment to my insurance company, and permit payment directly to San Mateo Rheumatology, any benefits due for services rendered there. I recognize and accept responsibility for any balance remaining.

Signed \_\_\_\_\_ Date \_\_\_\_\_

In Case of Emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

