THE CENTER FOR MEDICAL HEALING
Patient Registration

Patient Information

Last Name:____________________ First Name:_______________ Middle Initial: ____

Street Address: ____

City: __________________________ State: ______ Zip Code: ___________

Home Phone:___________________ Social Security Number:____________________

Cell Phone:____________________ Date of Birth: ____________________________

E-mail address:_______________________ Sex: □ male □ female

I authorize use of electronic communications (email/txt msg): Yes No (circle one)

Name of Employer: ____________________Work Phone: ______________________
Work Address:____

Marital Status: □ Single □ Widowed □ Separated □ Divorced
□ Married; Spouse's name: ____
□ Partnered; Partner's name: ____

Who referred you to Dr. Da Silva? ____

In Case of Emergency
Please Call: ____________________ Relationship: ___________Phone: ____________

Insurance Information
What is the name of your insurance company? _______________________________
ID number on your insurance card: ____
Name and relationship of insurance holder,(eg. Self, spouse, parent, etc.): _____________
Insurance Holder's date of birth (If not yourself): ____________________________
Do you have any secondary insurance? If so, what?_____________________________

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Dr. Annette DaSilva for any services furnished me by the doctor or her designees. **I understand that I will be responsible for any deductibles, co-payments, co-insurance, and non- covered services.** I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services, and to any party performing services of medical receivables on behalf of the doctor's office.

Cancellation Policy
You must provide at least 24 hours notice prior to cancellation of set appointment. Cancellations less than 24 hours prior to set appointment will result in a **$25.00** charge. Please indicate your agreement by signing below.

Signature of Patient: ______________________________ Date: _________________