Registration : **Helga Fuenfhausen Pizio, MD LTD**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate Age	Social Security #

Address

Address 2

Home Phone

Work Phone

Cell Phone

Email:

How did you hear of us?

City | State | Zip Code | Employer Name & Address | Occupation

Emergency Contact | Phone | Pharmacy | Phone

Pref Language: | **Race:** | **Ethnicity:** | **County:**

Provider | **Family Physician** | **Referring Physician**

Medical Insurance Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1					
2					
3					

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security #

Address | Home: | Work Phone | Email:

City | State | Zip Code | Employer Name & Address | Occupation

2. Last Name | First Name | Middle | Gender | Marital Status | Birthdate | Social Security #

Address | Home: | Work Phone | Email:

City | State | Zip Code | Employer Name & Address | Occupation

HIPAA Approved Contacts

1. Last Name | First Name | Middle | Gender | Birthdate | Social Security # | Relationship

Address | City | State | Zip Code | Home: | Cell: | Work Phone

HIPAA: list in the section above the person or family member to whom you wish to have access to your medical or insurance information

RACE: (circle one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White Declined to specify

ETHNICITY: (circle one): Hispanic or Latino NOT Hispanic or Latino Declined to inform

Language (circle one): English Spanish Other: _____________

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Helga Fuenfhausen Pizio, MD, LTD all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I acknowledge receipt or opportunity to recieve the practices' Notice of Privacy Practices. I authorize the practices to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.I had opportunity to recieve the practices' Notice of Privacy Practices. I authorize the practices to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature

X

Signature Date

Helga Fuenfhausen Pizio, MD LTD
PO Box 848198
Los Angeles, CA 90084
Phone: 702-485-5000
Email: officemanager@neweyeslasvegas.com

Please attach all pertinent insurance ID cards for photocopying.