Ocean Breeze Medical Group, Inc.

Registration Form

By initialing next to the phone number(s) below, I authorize Ocean Breeze Medical Group, Inc, its physicians and staff to provide to me detailed messages on my voicemail regarding medical information such as: test results, medications, referrals, authorization determination, etc. for my benefit of receiving the information in a timely manner.

Name:	Date of birth:	Sex: M/F	Social Security Number:

Address:	City:	State:	Zip Code:

Marital Status:	Spouse Name:	Home Phone Number:	Cell Phone Number:
Single		**INITIAL:**	**INITIAL:**

Occupation:	Employer:	Employer Phone #:

Address:	City:	State	Zip Code:

In case of emergency, name and phone number of person we may contact (not living with you):

Pharmacy Name: **City:** **Phone #:**

Email Address:

I the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ocean Breeze Medical, Inc, Dr. Davalos, and/or Dr.Ebrahimzadeh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship	Date