Apollo Health Care Center
Seema Sangwan, MD
877 W Fremont Avenue, Suite N-1
Sunnyvale, CA 94087

Patient Registration Form

Full Name:

_____
(First, Middle, Last)

Social Security Number (NEEDED FOR BILLING): _____

Date of Birth: _____ / _____ / _____ **Gender: (M / F)**

Home Address:

_____
(Number, Street, Apt/Suite)

_____
(City, State, Zip)

Phone Numbers:
Home: _____
Cell: _____
Work: _____ ext. _____
Other: _____

Preferred number to call: (Home / Cell / Work / Other);Okay to leave message? (Y / N)

E-mail address:

_____

Marital Status: (Single / Married / Divorced / Legally Separated / Life Partner / Separated / Significant Other / Widowed / Other)

Spouse Name: _____
Cell Phone: _____

In case of Emergency, please contact:

_____
(Name) (Relationship) (Phone)

Race / Ethnicity / Ancestry: (_____ / Prefer Not to Answer)

Hispanic Origin? (Y / N / Prefer Not to Answer)

Preferred Language: _____ Interpreter Needed? (Y / N)

Accommodation Needs (None / Hearing / Mobility / Speech / Vision / Other)

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Insurance Information

Traveled outside US in last 6 months? (Y / N) Specify:

_____

Primary Insurance (i.e., Medicare, Blue Cross, etc.):

_____

Policy or Member ID #:

_____

Group # (if applicable):

_____

Subscriber Name (if not self):

_____

Relationship: _____

Address: _____
(Number, Street, Apt/Suite)

_____
(City, State, Zip)

Date of Birth: _____
Social Sec #: _____
Phone: _____

P.O. Box for sending Medical Claims (see back of card):

_____
(P.O. Box) (City, State, Zip)

Secondary Insurance (i.e., Medicare, Blue Cross, etc.):

_____

Policy or Member ID #:

_____

Group # (if applicable):

_____

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Insurance Information

Subscriber Name (if not self):

_____

P.O. Box for sending Medical Claims (see back of card):

_____

(P.O. Box) (City, State, Zip)

Who may we thank for referring you?

_____