KENNETH B. MAYBURY, M.D.
INTERNAL MEDICINE
1 SHRADER ST., STE. 570, SAN FRANCISCO, CA 94117 TEL: (415) 422-0998 FAX: (415) 422-0903

Registration Form

Today's date		Prior doctor (if known):		
PATIENT INFORMATION				
Last name First name M.I.			Marital status: Single ☐ Married ☐ Domestic partner ☐ Divorced ☐ Widowed ☐	
Birth date	Age: Sex: ____ M ☐ F ☐	Social security no.:	Cell phone no.: _____ Home phone no.: _____	
Street address			Preferred ph. no. for contact: Cell ☐ Home ☐ Email: _____	
City			State	Zip Code
Occupation		Employer		Work phone:
Referred to this office by (check one): Friend ☐ Family member ☐		Hospital emergency room ☐ Close to home ☐	Insurance plan ☐ Internet search ☐	Other provider ☐ Other _____
Other family members seen at this office:				
Durable power of attorney for health care, name and phone:		**Preferred pharmacy**: Name, FAX #, ph., street, city		
INSURANCE INFORMATION				
PRIMARY INSURANCE				
Subscriber's name (if not self):		Name of Insurance	Subscriber's birth date:	
Patient's relationship to subscriber:		Self ☐ Spouse ☐ Child ☐ Other ☐		
SECONDARY INSURANCE				
Subscriber's name (if not self):		Name of insurance	Subscriber's birth date:	
Patient's relationship to subscriber:		Self ☐ Spouse ☐ Child ☐ Other ☐		
EMERGENCY CONTACT INFORMATION				
Name of local relative or friend (not living at same address):		Relationship to patient:	Phone number:	
FINANCIAL RESPONSIBILITY				
Visa ☐ MC ☐ Amex ☐		Credit Card Number:	Exp. Date: _____ / _____	CVC #: _____

The above information is true to the best of my knowledge. I authorize my Insurance Company to pay my insurance benefits directly to the Physician, Kenneth B. Maybury, M.D. I understand that I am financially responsible for any balances. I authorize Physician and Insurance Company to release information required to process claims. I authorize Physician to charge my credit card for unpaid balances due to his office, including balances for missed appointments not cancelled 24 hours in advance. I understand I will be provided notification of these charges in advance and with receipts.

Patient signature: _____ ***Date:*** _____