Michael T. Mosher, MD, FACAAI
A Medical Corporation

Diplomate of the American Board
of Allergy and Immunology

Patient Registration:

Patient Last name:_____ First name_____ MI:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Address:_____ City:_____Zip:_____

Home phone:_____Cell phone:_____Work Phone:_____

Email:_____

Social Security #:_____ Calif Driver's Lic :_____

Employer:_____ City:_____

Friend/relative for emergency Contact:_____Phone:_____Relationship:_____

WHO REFERRED YOU?:_____

PATIENT'S PRIMARY CARE PHYSICIAN:_____City_____Phone_____

PARENT'S – SPOUSE –INFORMATION

Relation to Patient: ____Spouse ____Parent ____Child ____Other

Soc.Sec No._____Driver's Lic#_____State_____Birthdate_____

Last Name:_____First:_____Mi._____Home Phone:_____

Address:_____City:_____Zip:_____

Employer:_____City: _____Work Phone:_____Cell Phone:_____

INSURANCE INFORMATION:

Primary Insurance Holder's Name_____

Relationship To Patient_____Birthdate_____

PRIMARY INSURANCE COMPANY: _____ID#_____

SECONDARY INSURANCE COMPANY:_____ID#_____

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE ABOVE NOTED INSURANCE COMPANY(S) BE MADE DIRECTED TO MICHAEL T. MOSHER, MD FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE, INCLUDING DEDUCTIBLE AND COPAYMENTS. I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NONPAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED. IF PATIENT IS A MINOR, AS PARENT AND/OR GUARDIAN, I HEREBY AUTHORIZE PHYSICIANS OF MICHAEL T. MOSHER, MD., A MEDICAL CORPORATION, TO TREAT MY CHILD.

SIGNED:_____ Date:_____

I, (print)_____have received a copy of this office's Notice of Privacy Practices.

SIGNED:_____ Date:_____