

DEMOGRAPHICS

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PLEASE PRINT

Patient Name: _____ Male ____ Female ____

If Patient is a Minor, Name of Parent/Responsible Party: _____

Address: _____ **Apt#:** _____ **Marital Status:** _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth ____ / ____ / ____ **Age:** ____ **Social Security #** _____

Driver's License # _____ **Occupation:** _____

Home Telephone # (____) _____ **Employer Name:** _____

Cell Phone # (____) _____ **Work Telephone #:** (____) _____

Email Address: _____

Insurance Company: _____

Emergency Contact: _____ **ID.No/SSN:** _____

Relationship: _____ **Insured Name:** _____

Telephone #: (____) _____ **Insured Date of Birth:** ____ / ____ / ____

Whom shall we thank for referring you? _____

Personal Physician: _____ **Telephone #:** (____) _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

AUTHORIZATION:

May we send your physician a report of our findings? Yes _____ No _____

I authorize the release of medical information to my insurance company: Yes _____ No _____

BILLING POLICY:

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medi-cal or legal liens.

I have read the above policy and understand my financial responsibility.

Signature: _____ **Date:** ____ / ____ / ____