SAN DIMAS FAMILY CARE, INC.

12-02

PATIENT INFORMATION (PLEASE PRINT):

NAME _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

SEX: M F DRIVER'S LICENSE NUMBER: _____ STATE: _____

MARITAL STATUS: ( )SINGLE ( )MARRIED ( )WIDOWED ( )DIVORCED ( )SEPARATED ( )PARTNER

PARENT / GUARDIAN NAME: _____ RELATIONSHIP: _____

HOME ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

HOME PHONE: ( ) _____ CELL PHONE: _____

EMPLOYER NAME: _____ OCCUPATION: _____

WORK ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

WORK PHONE: ( ) _____ Ext: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ PHONE: ( ) _____

INCOMPLETE INSURANCE INFORMATION MAY RESULT IN CLAIM DENIAL BY THE PAYER!

PRIMARY INSURANCE COMPANY: _____

ID / POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF SUBSCRIBER / INSURED: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____ PHONE NO: ( ) _____

SECONDARY INSURANCE COMPANY: _____

ID / POLICY NUMBER: _____ GROUP NUMBER: _____

NAME OF SUBSCRIBER / INSURED: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER NAME: _____ PHONE NO: ( ) _____

PLEASE SIGN AND RETURN TO THE RECEPTIONIST

I THE UNDERSIGNED, ASSIGN DIRECTLY TO SAN DIMAS FAMILY CARE, INC. ALL SURGICAL AND/OR MEDICAL 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 PAYMENT OF BENEFITS.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO SAN DIMAS FAMILY CARE, INC, WHICH MAY HAVE A BEARING ON MY CARE AND/OR TREATMENT.

SIGNATURE: _____ DATE: _____
(F THE PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENTS)

NOTE: Please notify us if any of the above information changes during the course of your treatment.

Excel: Pt Info Sheet 12-02