

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____
(street) (city) (state) (zip)

Date of Birth: _____ **Sex:** M F **Home Phone:** _____

Email Address: _____ **Cell Phone:** _____

SS# _____ **Marital Status:** _____ **Message Phone:** _____

Nearest Relative not living with you: _____ **Phone#** _____

Referring Doctor: _____ **Phone#** _____

Insurance Holders Name: _____ **Relationship:** _____

Patient's Employer Name: _____ **Phone#** _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____
(street) (city) (state) (zip)

Home Phone: _____ **SS#** _____

Name of Insurance Carrier: _____

Employer Name: _____ **Occupation:** _____

Patients Relationship to Guarantor: Same ___ Husband ___ Wife ___ Son ___ Daughter ___
Other _____

How did you hear about our office? _____

Insurance Clause: I understand that if this or any other visit precedes the effective date of my insurance; or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visits.

Treatment Consent: I hereby give consent for medical or surgical treatment to the above named physicians to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment.

Assignment of Payment of Benefits: I hereby authorize payment directly to Central California Faculty Medical Group, of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

Release of Information: I hereby give consent to release to authorized persons of financial and medical information concerning care and treatment and charges therefore as may be required to complete all claims for benefits.

Pt. Signature / Pt. Representative Signature

Date