

PATIENT INFORMATION

Name (print) _____ Date of Birth ____/____/____ Sex: F__M__ SSN# _____ - ____ - ____
MM DD YY

Home Address _____ City _____ State _____ Zip _____

Occupation _____ Employer's Name/Address _____

Work Address _____ City _____ State _____ Zip _____

Phone: Cell (_____) _____ Home (_____) _____ Work (_____) _____ Ext _____

Marital Status: S__M__D__W__ Spouse/Partner's Name _____

Name of Emergency Contact: _____ Phone(_____) _____

Insurance Carrier's Name _____ ID# _____

Insured Name _____ Date of Birth _____ Relationship To Insured _____

How Did You Hear About Us: Physician/Dentist _____ Friend _____ Yellow Pages _____
(Optional)

On-line Resources: Google Yahoo Bing Twitter Facebook Insurance Directory Other _____

I verify that the above information is true and correct. I understand that I alone am responsible for payment of fees, for services rendered, and that such payment is due at the time of service. In the event that this office does bill my insurance, I hereby give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed. I hereby authorize this office to release my medical information to my insurance company and assign my insurance benefits to be paid directly to the doctors and providers under Downtown Medical Group. I am responsible for deductible, co-insurance, co-payments, and non-covered portions and services.

I hereby authorize the doctors and/or designated staff of this office to perform all recommended diagnostic laboratory test procedures and treatment as medically necessary and in the interest of preventative care as required to provide proper care, which may or may not be covered by my health insurance policy.

This office however cannot accept responsibility for collecting your insurance payment in full or negotiating a settlement of a disputed claim. Most misunderstandings about payment can be avoided by understanding what your insurance covers. Please read our financial policy on the reverse of this page.

I understand the physicians are licensed and regulated by the Medical Board of California (800) 633-2322, www.mbc.ca.gov

Patient's Signature _____ Date _____

Thank you for selecting our office for your health care needs. We sincerely appreciate your referral of friends and associates who need a doctor and offer our thanks for giving us the opportunity to serve them as well as you.