PATIENT

☐ MALE ☐ FEMALE

PATIENTS NAME_____
LAST FIRST MIDDLE

PATIENTS ADDRESS_____
STREET CITY STATE ZIP CODE

PATIENTS HOME PHONE (_____)_____ - _____ PATIENTS CELL PHONE (_____)_____-_____

PRIMARY CARE PHYSICIAN _____

MARITAL STATUS: _____ SINGLE _____MARRIED _____ DIVORCED _____WIDOWED

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____

PARENTS NAME (IF MINOR) _____ BEST CONTACT NUMBER (_____)_____-_____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

WORK PHONE _____ OCCUPATION _____

RACE:

☐ NATIVE AMERICAN ☐ CAUCASIAN ☐ INDIAN (ASIA)

☐ ASIAN ☐ FILIPINO ☐ MULTI-RACIAL

☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC/LATINO ☐ PACIFIC ISLANDER

☐ OTHER/DECLINE TO STATE_____

PREFERRED LANGUAGE SPOKEN BY PATIENT:

☐ ENGLISH ☐ JAPANESE ☐ SPANISH

☐ ARABIC ☐ KOREAN ☐ THAI

☐ CHINESE ☐ FARSI ☐ VIETNAMESE

☐ HEARING IMPAIRED ☐ OTHER-PLEASE SPECIFY _____

ETHNICITY

☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ UNKNOWN/DECLINE

PREFERRED METHOD OF CONTACT

CIRCLE ONE

HOME PHONE YES / NO OKAY TO LEAVE MESSAGE ☐ YES ☐ NO

CELL PHONE YES / NO OKAY TO LEAVE MESSAGE ☐ YES ☐ NO

WORK PHONE YES / NO OKAY TO LEAVE MESSAGE ☐ YES ☐ NO

EMAIL ADDRESS -_____

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT PERSON _____RELATIONSHIP_____

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE (____)_____-_____CELL PHONE (____)_____-_____WORK PHONE (____)_____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

PLEASE CIRCLE ONE
HMO / PPO / PRIVATE

INSURANCE COMPANY NAME: _____

CIRCLE ONE
MALE / FEMALE

NAME OF INSURED: _____ DATE OF BIRTH:____/____/_____
LAST FIRST MIDDLE

ADDRESS:_____
STREET CITY STATE ZIP CODE

SOCIAL SEC #: _____/_____/_____ RELATION TO PATIENT:_____SELF_____ CHILD_____SPOUSE_____OTHER

INSURANCE ID#: _____ GROUP#: _____

HOSPITAL NETWORK: _____HOAG _____SADDLEBACK _____ OC MEMORIAL

SECONDARY INSURANCE INFORMATION

PLEASE CIRCLE ONE
HMO / PPO / PRIVATE

INSURANCE COMPANY NAME: _____

CIRCLE ONE
MALE / FEMALE

NAME OF INSURED: _____ DATE OF BIRTH:____/____/_____
LAST FIRST MIDDLE

ADDRESS:_____
STREET CITY STATE ZIP CODE

SOCIAL SEC #: _____/_____/_____ RELATION TO PATIENT:_____SELF_____ CHILD_____SPOUSE_____OTHER

INSURANCE ID#: _____ GROUP#: _____

HOSPITAL NETWORK: _____HOAG _____SADDLEBACK _____ OC MEMORIAL

ACCIDENT INFORMATION

ACCIDENT DATE: _____/ _____/ _____ TIME:_____ ☐ AM ☐ PM

PLACE:_____WORK RELATED? ☐ YES ☐ NO

PLEASE EXPLAIN WHAT HAPPENED:_____
_____
_____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians/providers, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits/coverage and tests ordered by my doctor may not be covered.** I will be financially responsible for all charges that are not covered by my insurance company. I understand that will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

PATIENTS SIGNATURE_____ DATE_____