

Douglas Hamilton M.D. ***Shanah Gavia MPA-C**

PLEASE PRINT CLEARLY!

DATE: _____

PATIENT'S FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

SEX: _____ DOB: _____ SOCIAL SECURITY: _____ DRIVERS LICENSE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE CHECK WHICH NUMBER YOU WOULD LIKE AS YOUR PRIMARY NUMBER.

- ☐ HOME PHONE: _____
☐ CELL PHONE: _____

WE CONFIRM APPOINTMENTS BY EMAIL.

E-MAIL ADDRESS: _____

Are you interested in receiving emails on new information and discounts? Yes or No

OCCUPATION: Advertising/Agriculture/Architecture/Art & Entertainment/Aviation/Childcare/Construction & Maintenance/Education/Engineering/Financial service/Executive/Healthcare/Human Resources/ Insurance/Internet/Law/Law Enforcement/Marketing/Real Estate /Retail/ Telecommunications/ OTHER: _____

EMPLOYED BY: _____

EMPLOYER'S ADDRESS: _____

NAME OF SPOUSE: _____

SPOUSE BIRTH DATE: _____

SPOUSE EMPLOYED BY: _____

EMPLOYER'S ADDRESS: _____

WORK PHONE NO.: _____

REFERRED BY: _____

NAME AND ADDRESS OF CLOSEST RELATIVE (IN CASE OF EMERGENCY)

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE NO.: _____

DO YOU HAVE HEALTH INSURANCE? YES _____ NO _____

IF YES, PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD(S) AND ID CARD.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ABOVE NAMED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS , IF ANY. OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED ON ATTACHED CLAIM.

X SIGN: _____ DATE: _____

PAYMENT OF SERVICES:

I REALIZE THAT THIS MAY NOT REPRESENT THE FULL PAYMENT FOR SERVICES RENDERED AND I WILL BE RESPONSIBLE FOR THE BALANCE DUE.

X SIGN: _____ DATE: _____

ATTENTION; We currently **DO NOT** accept **Blue Cross Covered California EPO, HMO or PATHWAY** Insurance plans
(Providence referrals excluded)