Sana Medical Group

PATIENT INFORMATION SHEET

First: _____Last: _____ D.O.B:_____/_____/_____ Sex: □M □F

Social Security # _____-_____-_____ DL#_____ Marital Status: □S □M □D □W

Email:_____@_____ Pref Lang. □Eng □Span□ Other_____ Race_____

May authorize caregiver to review and access EHR:Name:_____email_____@_____

HomeAddress_____City_____ST____Zip_____

Home # (____)_____-_____ Cell #(____)_____-_____ Work # (____)_____-_____

Occupation_____Employer_____

WorkAddress_____City_____ST____Zip_____

Spouse/Sig.Other Name: _____ Tel:(____) _____-_____

Emergency Contact_____ Relation_____ Tel:(____) _____-_____

INSURANCE INFORMATION

Medicare # _____ Medi-Cal #_____

- **Primary Insurance HMO/PPO**

Subscriber's Name: _____ D.O.B.: ____/____/____

ID Number:_____ Group Number:_____

Health Plan: _____IPA/Medical Group: _____

- **Secondary Insurance**

Subscriber's Name: _____ D.O.B.: ____/____/____

ID Number:_____ Group Number:_____

I the Subscriber, herby attest and agree that should the patient or (I) later be determined "ineligible" for services rendered by Sana Medical Group Inc. I will be held responsible for payment. If the patient is under 18 the subscriber is responsible for payment.

Subscriber Signature: _____ Patient Signature _____

INSURANCE CLAIM PROCESS CLAIM RELEASE AUTHORIZATION

I authorize Sana Medical Group Inc. to release my medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I also authorize to apply for benefits on my behalf for services covered by this office. I request the payment from my insurance company be made directly to Sana Medical Group Inc. I certify that the information I have reported with regards with insurance coverage is correct. I permit a copy of this authorization to be used in place of the original

AUTHORIZATION FOR TREATMENT /NOTICE OF PRIVACY PRACTICE

I herby authorize Sana Medical Group staff to render services that may be deemed necessary for my medical care. If the patient is under 18, the parent/guardian authorizes care at Sana Medical Group. I have been provided a copy of Sana Medical Group's Notice of Privacy Practice.

I have read and understood both portions of this document and herby give my authorization to Sana Medical Group Inc.

Signature _____ Date_____

Patient or Legal Guardian