PATIENT INFORMATION

Name (print) _____Date of Birth____/____/____Sex: F__M__SSN#_____-____-_____
MM DD YY

Home Address_____City_____State_____Zip_____

Occupation _____Employer's Name _____

Email Contact Address_____

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.

Downtown Medical Group
450 Sutter Street, Suite 1723, San Francisco, CA 94108