LUCIA S. OLARTE, MD **TEL: 310-556-7715**
2080 CENTURY PARK E, STE #1700, LOS ANGELES, CA 90067 FAX: 310-201-5902

Patient's Name _____
LAST FIRST MIDDLE

Address _____

Home Phone _____ Cell Phone _____

Email address _____ Male ____ Female ___

By providing your email address, you will be given the ability to view your electronic medical record and communicate directly with your physician by email. If you do not provide your email address, you are choosing not to have access to your electronic medical record or to communicate by email.

Date of Birth ____/____/____ **Age** ____ **Marital Status** _____

Social Security # _____ **Driver's License #** _____

Patient's Employer _____ **Occupation** _____

Pharmacy Name: _____ **Street** _____ **Phone** _____

Insurance Carrier: _____ **Insured Name** _____

ID. No/SSN _____ Insured Date of Birth ____/____/____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____ Other _____

Personal Physician _____ Address _____

City _____ State _____ Zip Code _____ T: _____

Whom shall we thank for referring you? _____

May we send your physician a report of our findings? Yes _____ No _____

Please list the specific areas you would like to discuss today:

_____

AUTHORIZATION:

I authorize the release of medical information to my insurance company: Yes _____ No _____

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept Medical or lega liens.

I have read the above policy and understand my financial responsibility.

Signature: _____ **Date:** _____