SPANISH
PLEASE ANSWER IN ENGLISH

BAYVIEW GENERAL MEDICINE

TELEFONO_____

FETCHA_____ TELEFONO DE SU CASA_____

NOMBRE_____

PESONA RESPONSABLE (SI ES UN MENOR) _____

DIRECCION_____

CIVDADA_____ESTADO_____LODICO POSTAL_____

SEX ( ) HOMBRE ( ) MUJER EDAD_____ FECHA DE NACIMIENTO_____

CASADO _____ SOLTERO _____ VIVDO _____ SEPARADO_____DIVORCIADO_____

LUGAR DE TRABAJO DEL PACIENTE Y TELEFONO_____

LUGAR DE TRABAJO DEL ESPOSO (A) Y TELEFONO_____

PROPOSITI DE LA VISITA_____

PERSONA RESPONSIBLE DE LA CUENTA_____

RELACION CON EL PACIENTE_____

SEGURO SOCIAL _____SEGURO SOCIAL DE LA ESPOSA(O)____

FORMA DE PAGO _____CASH_____MC/VISA_____AMEX

TIENE SGURO MEDICO_____NO_____SI (IF SI)

NOMBRE DEL SEGURO PRINCIPAL_____

NOMBRE DEL SEGURO ADICIONAL_____

EN CAS DE EMERGENCIA NOTIFICAR A _____TELEFONO_____

COMO FUE REFERRIDO A ESTA OFICINA_____

EMAIL ADDRESS_____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I _____hereby authorize _____ to pay and hereby assign directly to Richard W Blanchar M.D. all benefits, otherwise payable to me for his services as described on the attached forms. I understand that I am financially responsible when received by and paid to_____ will be credited to my account, in accordance with the above said assignment.

FIRMA_____ FETCHA_____

SPANISH
PLEASE ANSWER IN ENGLISH