PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. **Please print** and **fax it back to our office: 714.955.5965**. All information will be confidential.

Date: _____ Patient Name _____
FIRST M.I. LAST

SS # _____ Φ Male Φ Female Date of Birth _____ Driverôs License # _____

Address _____City _____ State _____ Zip code _____

E-Mail _____ Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: Φ Single Φ Married Φ Divorced Φ Separated Φ Widowed

Ethnic Group: Φ Hispanic or Latino Φ Non Hispanic or Latino

Ethnicity: Φ American Indian or Alaska Native Φ Asian Φ Black or African American Φ Caucasian
Φ Native Hawaiian or Other Pacific Island Φ Other

Preferred Language: Φ English Φ Spanish Φ Other _____

Name of Primary Physician _____ Phone _____

Address of Primary Physician _____City _____ State ____ Zip code _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

X_____ _____
PARENT OR GUARDIAN SIGNATURE DATE

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

E-Mail _____ Cell phone _____

Driverôs License # _____ Date of Birth_____

Employer _____ Work Phone _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Date of Birth _____ SS # _____

Insurance Company _____ Group # _____ Insurance ID # _____

Do you have any additional insurance? Φ Yes Φ No If yes, complete the following:

Name of Insured _____ Relationship to patient _____

Date of Birth _____ SS # _____

Insurance Company _____ Group # _____ Insurance ID # _____

I authorize release of any information concerning my (or my childôs) health care, advice and treatment provided for the pupose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
PATIENT OR PARENT/GUARDIAN SIGNATURE **DATE**