Bruce R. Hoyle MD Inc
Tel. 714.955.5960 Fax. 714.955.5965

1120 W. La Veta Ave, Ste 830
Orange, CA 92868

PATIENT INFORMATION

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

SS # _____ □ Male □ Female Date of Birth _____ Driver's License # _____

Address _____ City _____ State _____ Zip code _____

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

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

Ethnic Group: □ Hispanic or Latino □ Non-Hispanic or Latino

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

Preferred Language: □English □Spanish □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 _____

Responsible Party

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

Address _____ Home Phone _____

E-Mail _____ Cell phone _____

Driver's License # _____ Date of Birth _____

Employer _____ Work Phone _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for allowing us to be a part of your healthcare. It is our desire to provide high quality medical care for our patients. The established financial policy of this office is that full payment is due at the time of service. The following is a statement of our Financial Policy which we require that you read, agree to, and sign before any treatment.

PAYMENT OPTIONS – We accept cash, checks (up to $400), MasterCard, Visa and Discover. **Returned checks will result in a $25 fee** that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees.

CANCELLATION POLICY – We require a 48 hour notice for appointment cancellation. **Failure to show for a scheduled confirmed appointment may result in a $50 cancellation fee.**

My signature below constitutes acknowledgement and acceptance of this policy.

Patient Name: (Please Print) _____

Patient Signature _____

Date: _____