SIMONE A. MCKITTY, M.D. INC.
3440 W Lomita Blvd, Suite 442 Torrance, California 90505 (310) 530-5451

Information for Patient Case History

(PLEASE PRINT)

PATIENT NAME ______________________________ DATE ____________
LAST FIRST MIDDLE INITIAL

ADDRESS ____________________ CITY ____________ STATE ______ ZIP ____________

HOME PHONE ( ) ____________ WORK PHONE ( ) ____________ BIRTHDATE ____/____/____

SS# ____________ SEX ________ MARITAL STATUS ____________ AGE ________

REFERRED BY: ____________ FAMILY PHYSICIAN ____________

EMPLOYER ____________ OCCUPATION ____________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ____________ PHONE ( ) ____________

OTHER FAMILY MEMBERS THAT ARE PATIENTS ____________

PARENT OR RESPONSIBLE PARTY ***(IF DIFFERENT FROM PATIENT)***

NAME ____________ HOME PHONE ( ) ____________ WORK PHONE( ) ____________
LAST FIRST

MAILING ADDRESS ____________ CITY ____________ STATE ______ ZIP ____________

INSURANCE INFORMATION ***(PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)***

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME ____________	NAME ____________
INS ADDRESS ____________	INS ADDRESS ____________
NAME OF INSURED ____________	NAME OF INSURED ____________
INSURED'S ID# ____________	INSURED'S ID# ____________
SS# ____________ BIRTHDATE ____/____/____	SS# ____________ BIRTHDATE ____/____/____
GROUP # ____________	GROUP # ____________
EMPLOYER ____________	EMPLOYER ____________
EMPLOYER PHONE ( ) ____________	EMPLOYER PHONE ( ) ____________

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Simone A McKitty, M.D. the release of medical information to my primary care or referring physician, to consultants if needed and as necessary concerning my illness to process insurance claims, insurance applications and prescriptions. I also authorize payment of all benefits to which I am entitled directly to Simone A McKitty, M.D. for services rendered and/or related medical expenses. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check or credit card. I understand and agree that I am financially responsible for all charges whether or not covered by my insurance. A photocopy of this authorization/assignment may serve as the original. Your signature below signifies your understanding and willingness to comply with this policy.

______________________________ ____________________
PATIIENT OR RESPONSIBLE PARTY SIGNATURE DATE