

PATIENT INFORMATION

In order to serve you properly, we need the following information from you. All information is strictly confidential.

Patient Name _____ Birth date _____ Age _____
Address _____ City/St/Zip _____ Sex _____

Phone number _____ martial status _____ Social Security # _____

Employer _____ Phone number _____

Person to contact in case of emergency: _____ phone _____

Primary Doctor _____ phone _____

Responsible Party

Person responsible for this account: _____ relationship to patient _____

Address, if different than patient _____

Phone _____ Birth date _____

Insurance Information

Name of insured _____ relationship to patient _____

Birthdate: _____ Social Security # _____

Primary Insurance _____ ID# _____ Group # _____

Secondary Insurance _____ ID# _____ Group # _____

Please note that it's the patient's responsibility to provide & maintain a current referral for all HMOs

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim(s). I request that payment under the medical insurance program be made to me or Edward A. Legarreta, MD for services provided to me.

Signature _____ Date _____

I authorize the release of any information concerning my health care or that of my child's, and treatment provided for the purpose of processing and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor. I understand that I am financially responsible for all balances and non-covered procedures and services.

Signature _____ Date _____