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_________________________