

HARBOR MEDICAL GROUP, INC. PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly we need the following information.

Please print. All information will be confidential.

DATE: PATIENT NAME: FIRST M.I. LAST

Have you ever used another last name? Yes No If yes, please list:

CA Driver's Lic.: SSN: Birthdate: Home Phone:

Address: City: ST: Zipcode:

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient's or parent's employer: Work Phone #:

Businessaddress: City: ST: Zipcode:

Spouse or Parent's name: Employer: Work Phone:

If patient is a student, name of school/college: City: ST:

Whom may we thank for referring you?

Person to contact in case of emergency: Phone #:

Relationship to patient?

Patient's primary care physician: Phone #:

Allergies?:

INSURANCE INFORMATION

PRIMARY INSURANCE ONLY: (Please give a copy of your insurance card to the receptionist.)

Name of Insurance Carrier:

Subscriber: Relationship to Patient:

Identification #: Group #:

If you are covered by Medi-Cal or Medi-Cruz, you must give us the proper card and/or papers to submit with our bill.

Medi-Cal Identification #:

SECONDARY INSURANCE: (Please give a copy of your insurance card to the receptionist.)

Name of Insurance Carrier:

Subscriber: Relationship to Patient:

Identification #: Group #:

RELEASE OF INSURANCE INFORMATION

I authorize any holder of medical or other information about me to release this information to the Social Security Administration, Health Care Financing Administration, my insurance company or its immediacies or carriers, or to this physician's office or my attorney or other doctor's office. As a courtesy, Harbor Medical Group will bill your insurance company. You are primarily responsible for determining what your insurance will cover, whether you require a referral, and/or payment of your bill.

I authorize direct payment of medical benefits and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Harbor Medical Group, Inc. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Patient's Signature Date