PATIENT INFORMATION

Account #______________________________
Date ________________________________

Patient's Name ____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Last First Middle

Address:____
Street Apt # City State Zip

Home Phone (_______) ________________________ Cell Phone (______)___________________

Birth Date _____/____/____ Age______ Sex (M/F) Driver's License # ___________________

Social Security _________________________

Patient's Employer: __________________________________Work Phone #_________________
Occupation: __________________________

Employer's Address: ____
Street City State Zip

Who to notify in case of emergency? ____

Relationship to you?_______________________Daytime phone number: __________________

How were you referred to our office? ☐ *Physician* ☐ *Friend* ☐ *Insurance* ☐ *Internet*
☐ *Patient in building* ☐ *Sign outside* ☐ *Health Fair/Seminar*
☐ *Advertisement* *(check publication)* ☐ *Press Telegram* ☐ *Sun* ☐ *Grunion* ☐ *News Enterprise* ☐ *Other*

Would you like to be notified of any new products, services or specials via e-mail? ☐ **Yes** ☐ **No**
No medical test results will be sent via e-mail.
E-mail address: ____

INSURANCE INFORMATION:

Medicare # ___________________________________ Is Medicare Primary ☐ or Secondary ☐

Insurance Carrier's Name: ____

Billing address: ____
Street City State Zip

Insurance phone # ___________________________

Insured's Name: ____________________________ Insured's Date of Birth __________________

Social Security or ID of Insured #______________________ Group #______________________

Please complete the following if the insured is other than self….

Insurer's Employer: ________________________________Occupation: _____________________

Address: ____
Street City State Zip

Work Phone # ____________________Patient's relationship to insured: Spouse Child

Office Use Only
Arbitration Form ☐ Accepted ☐ Rejected

Form 003B

3772 KATELLA AVE., SUITE 206 LOS ALAMITOS, CA 90720 • (562) 430-4294 • FAX (562) 493-3573