PATIENT INFORMATION FOR MEDICAL RECORDS – *PLEASE PRINT CLEARLY*

NAME (Mr. Mrs. Ms.) _____
Last First M.I.

HOME ADDRESS _____

_____
City State Zip

MAILING ADDRESS _____
(If different from above) Street Address City State Zip

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

D.O.B. _____ AGE_____ SEX_____ SSN _____ MARITAL STATUS: MARRIED SINGLE MINOR

REFERRED BY _____ PHONE #_____

PRIMARY CARE DR._____ PHONE #_____

EMPLOYED BY _____ OCCUPATION_____

WORK ADDRESS _____

EMERGENCY CONTACT _____ PHONE NUMBER _____
Last First
RELATIONSHIP TO PATIENT _____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION

NAME OF RESPONSIBLE PARTY_____ RELATIONSHIP TO PT_____

ADDRESS _____ SSN_____

EMPLOYED BY_____ WORK PHONE _____ HOME PHONE_____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CO._____ ADDRESS_____

POLICY NUMBER_____ PHONE NUMBER_____GROUP NAME/#_____/_____

SECONDARY INSURANCE CO. _____ ADDRESS_____

POLICY NUMBER_____ PHONE NUMBER_____GROUP NAME/#_____/_____

IF YOUR INJURY IS JOB RELATED, PLEASE NOTIFY A STAFF MEMBER

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO SAN DIEGO GENERAL AND VASCULAR SURGEONS MEDICAL GROUP, INC ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE SAN DIEGO GENERAL AND VASCULAR SURGEONS MEDICAL GROUP, INC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE **X**_____ **DATE**_____
IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENT

NOTE: PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF YOUR TREATMENT