Patient Information:

Last Name	First Name	Middle Initial
Street Address	City/State/Zip	SSN
Phone #	DOB	Gender
Cell Phone / Email		Marital Status
Emergency Contact/Phone #	Preferred Pharmacy Name & Phone #	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip	

Referred By: (How did you hear about the Doctor?)

Referred By:		
Primary Care Physician:	Address	Phone #

Insurance Information:

Name of First Insurance Co	Name of Second Insurance Co		
Street Address	City	State	Zip
Insurance ID #	Group #		

Subscriber Information (Policyholder if different from patient):

Relationship to Patient	Name	DOB
Address if different from Patient		Phone #

I hereby assign payment directly to the Providers of this office for any medical/surgical procedures performed. I agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest, on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of California.
I further authorize any holder of medical or other information about me to release the Social Security Administration its carriers of insurance Companies, any information needed for this or related Medicare or insurance claims. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Authorized Representative:	Date