Office Use only - ❑ NEW PATIENT ❑ ESTABLISHED ❑ UPDATE

IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC
PATIENT INFORMATION

DATE: _____ DOCTOR: _____

ACCOUNT # _____

PATIENT IDENTIFICATION

PLEASE PRINT

LAST NAME FIRST MIDDLE **SEX** ❑ M ❑ F			**RACE** (circle):Am.Indian/Alaska Native/Asian/Black/White/ Hispanic/Other Race/ None Reported **ETHINICITY** (circle): Hispanic/Non-Hispanic/Refuse to Report **LANGUAGE** (circle): English/Spanish/Indian/Other
AGE	DATE OF BIRTH	STREET ADDRESS / MAILING (If Different)	APT. NO.
CITY	STATE	ZIP CODE	
HOME PHONE	BUSINESS PH #: CELLULAR PH #: **EMAIL:**	MARITAL STATUS ❑ Single ❑ Married ❑ Divorce ❑ Minor *	SOCIAL SECURITY #
EMPLOYER (PATIENT OR ❑ * PARENTS OF MINOR)			SPOUSE'S NAME
PERSON TO NOTIFY (NAME & ADDRESS OF RELATIVE OR FRIEND NOT LIVING WITH YOU)			TELEPHONE NUMBER
REFERRED BY	PHARMACY INFORMATION:		

FINANCIAL RESPONSIBILITY

❑ PATIENT IS A MINOR – *PARENT INFORMATION

LAST NAME FIRST	SOCIAL SECURITY	DATE OF BIRTH	RELATIONSHIP TO PT
ADDRESS			
HOME PHONE	BUSINESS PHONE	EMPLOYER ADDRESS (PARENT INFORMATION)	

INSURANCE – PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

NAME OF PRIMARY INSURANCE CO.		ADDRESS	
MEMBER I.D. #	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME/DOB
NAME OF SECONDARY INSURANCE CO.		ADDRESS	
POLICY OR CERTIFICATE #	GROUP #	EFFECTIVE DATE	POLICYHOLDER'S NAME/DOB

FINANCIAL AGREEMENT -

- I CONSENT TO TREATEMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT.
- I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING OR PRIMARY CARE PHYSICIANS AND TO MY INSURANCE COMPANY, MEDICARE OR MEDI-CAL, IF APPLICABLE.
- I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED BY THE PHYSICIAN AND AUTHORIZE TRANSFE OF ALL UNPAID AMOUNTS TO MY ACCOUNT FROM THE DATE OF SERVICE.
- I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.
- I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO **IMPERIAL VALLEY FAMILY CARE MEDICAL GROUP, APC.**

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SIGNATURE DATE

INCOMPLETE FORMS WILL NOT BE ACCEPTED

REVISED 06/2011