

WALNUT CREEK MEDICAL GROUP

Which doctor are you seeing today? _____ Date: _____

In order to serve you properly we will need the following information. (PLEASE PRINT) All information will be strictly confidential.

| | | | | | |
|--|------------------------------------|-------------------------|--------------------------|------------------|-----|
| Patient's name | | Home Phone | Birthdate / / | Marital status | Sex |
| Residence Address | | City | State | Zip Code | |
| If patient is a child, parent, or guardian's name | | | Cell Phone | | |
| Social security number | | | Driver's license number | | |
| Emergency Contact | | Relationship to patient | Phone | | |
| Name of employer | | Business address | | Business phone * | |
| Occupation | | | | | |
| Insurance company name and address * | | | | | |
| Subscriber Name | | | Policy no. | | |
| Subscriber Social Security Number | | | Subscriber Birthdate / / | | |
| Is there secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Insurance company name and address | | | | |
| Policy no. | Subscriber name | | | | |
| Person financially responsible for this account: <input type="checkbox"/> Self <input type="checkbox"/> Other: _____ | | Address | | | |
| If patient is child, who may authorize treatment for child? | | Relationship to child | Phone | | |
| Whom should we thank for referring you? | | | Email Address | | |
| Do you have a telephone answering machine? Yes No. If so, may we leave messages from this office on that machine? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| I have received a copy of the office's "Notice of Privacy Practices" Yes _____ Declined _____ <div style="text-align: center; font-size: small;"> Initial Initial </div> | | | | | |
| * I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage. Failure to pay co-payment at time of service will result in denial of service and a finance charge. | | | | | |
| Patient, Parent or Guardian Signature _____ | | | | Date: _____ | |