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Tel: 949-552-2100 | Fax: 949-552-1400

CONFIDENTIAL PATIENT INFORMATION

These forms are legal documents and are necessary to bill insurance and are a part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

GENERAL INFORMATION

Date: _____

First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Gender: Male ___ Female ___ Marital Status: S M D W Number of Children _____

Date of Birth _____ Age _____ Email Address _____

Driver License # _____ Social Security # _____

Employer Name _____ Occupation _____

Address of Employer _____ City _____ State _____ Zip _____

Name of spouse _____ Spouse's Employer _____

Name of nearest relative not living with you _____

Address _____ Phone _____

Is the condition you are here for the result of a work related injury? YES NO (circle one)

(If YES, have you reported it to your supervisor?) YES NO (circle one)

Is the condition you are here for the result of an automobile collision? YES NO (circle one)

How do you intend to pay for today's visit? _____

Do you have health insurance? YES NO Insurance Company _____

(If YES, please provide the receptionist with a copy of your insurance card.)

Name of policy holder _____

Relationship: Self ___ Spouse ___ Parent ___ Other ___

Who referred you to our office?

___ A friend/relative/co-worker/other referred me. Name of person _____

___ Website/Internet Listing. Which search engine? Google Yahoo Other _____

___ I met the doctor/representative at 24 Hour Fitness.

___ Yellow Pages. Which book? AT&T Yellowbook

___ Other. Please describe source: _____

"I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. **However, I clearly understand that I am responsible for the payment of all services rendered to me if my insurance company, for whatever reason, does not pay for services rendered to me.** I also understand that if I terminate my care, any fees for professional services rendered me will become due and payable."

Patient/Parent/or Guardian Signature

Date