DOCTOR: _____ PATIENT ACCT # _____

PATIENT INFORMATION FOR MEDICAL RECORDS – PLEASE PRINT

Last Name _____ First Name _____ M _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( )_____ Email address: _____

Sex M F Marital Status S M Birth Date _____/_____/_____

Social Security Number _____ / _____ / _____ Age _____

Patient's Employer _____ Occupation _____

Referred by Whom _____ *Family Physician* _____

In case of Emergency Contact _____ *Relationship to Patient* _____

Home Phone ( ) _____ *Work Phone ( )* _____

IF PATIENT IS A MINOR, PLEASE COMPLETE USING PARENT INFORMATION:

Father's Name _____ Employer _____

Work Phone ( ) _____ Social Security Number _____

Mother's Name _____ Employer _____

Work Phone ( ) _____ Social Security Number _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? YES NO

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co _____	Insurance Co _____
If HMO which IPA: Seaview Valley Care Ojai Valley BVMG	If HMO which IPA: Seaview Valley Care Ojai Valley BVMG
Subscriber # _____	Subscriber # _____
Group # _____	Group # _____
Subscriber _____ DOB:_____	Subscriber_____ DOB:_____
Subscribers Relationship to Patient_____	Subscriber's Relationship to Patient _____
Co-payment $ _____	Co-payment $ _____

CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

AUTORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION AND FINANCIAL AGREEMENT.
I/WE DIRECTLY ASSIGN ALL MEDICAL/SURGICAL BENEFITS TO THE ORTHOPEDIC SURGEON AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE ORTHOPEDIC SURGEON TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

_____ _____ _____

Patient Signature or Legal Guardian Print Name Date