FAMILY MEDICAL CENTER

Dr. J. Patel, M.D. | 30110 Crown Valley, Suite 101 | Laguna Niguel, CA 92677 | Tel: (949) 363-5322

PATIENT INFORMATION

PATIENT'S NAME	☐ MALE ☐ FEMALE	MARITAL STATUS S M DIV SEP WID	DATE OF BIRTH	DRIVERS LIC. NO.

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S EMPLOYER(Father's Employer If Minor)	OCCUPATION (Indicate If Student)	HOW LONG EMPLOYED?	SOCIAL SECURITY NO.

EMPLOYER'S STREET ADDRESS	CITY / STATE / ZIP CODE	BUSINESS PHONE NO.

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT: TEL	FAX WORK HOME

SPOUSE'S NAME(Mother's Name If Minor)	FATHER'S NAME IF MINOR	EMAIL WORK HOME

SPOUSE'S EMPLOYER (Mother's Employer If Minor)	OCCUPATION (Indicate If Student)	HOW LONG EMPLOYED	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

WHO PREPARED YOU TO THIS PRACTISE? (Please Circle)

☐ Relative ☐ Friend ☐ Yellow Pages ☐ Insurance Book ☐ Pass By Walk-in ☐ Attoney ☐ Employer ☐ Hospital ☐ Physician ☐ Visitor ☐ Other

PREVIOUS PHYSICIAN'S NAME

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT. IF NOT ABOVE	HOME PHONE NO.

STREET ADDRESS, CITY, STATE AND ZIP CODE

☐ COMPANY NAME AND ADDRESS

NAME OF POLICY HOLDER	CERTIFICATE NO.	GROUP NO.

☐ MEDICARE	MEDICARE NO.

In order to control our cost of billing, We request that office visites be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees

Method of Payment: ☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ Discover ☐ Other

AUTHORIZATION: I hereby authorize Family Medical Center or the physicians indicated above to furnish information to insurance career concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I agree to assume total responsibility in notifying any changes of my medical insurance coverage or change of address to Family Medical Center as soon as possible. I understand that I am financially responsible for all charges whether or not covered by insurance. I also understand that if I do not pay as services rendered, a service charge of 3/4% per month will be added each month if there is an outstanding balance. Should this account become delinquent I understand that I am responsible for any or all legal representative, court cost and collection charges involved as a result of any collection activity.

Signature of Responsible Party: Date:

I confirm that the above details are unchanged and that I agree to abide by the terms as before.

Date Signature

Date Signature

Date Signature

Date Signature