San Dimas Family Practice **Patient Information Form** **Date:**

1 ***PATIENT INFORMATION (PLEASE PRESS DOWN FIRMLY WHEN PRINTING CLEARLY):***

NAME (Last) (First) (Middle Initial)

DATE OF BIRTH: ______ SOCIAL SECURITY NUMBER: ______

SEX: M F DRIVER'S LICENSE NUMBER: ______ STATE: ______

MARITAL STATUS: ( )SINGLE ( )MARRIED ( )WIDOWED ( )DIVORCED ( )SEPARATED ( )PARTNER

SPOUSE / PARENT / GUARDIAN NAME: ______ RELATIONSHIP: ______

2 ***HOME ADDRESS:***

STREET ADDRESS APT / SPACE NO. CITY STATE ZIP

HOME PHONE: ( ) CELL PHONE: ______

EMPLOYER NAME: ______ OCCUPATION: ______

WORK ADDRESS:

STREET ADDRESS CITY STATE ZIP

WORK PHONE: ( ) Ext: CELL PHONE: ( )

3 **DAYTIME EMERGENCY CONTACT:** ______ RELATIONSHIP ______

PHONE: ( ) CELL PHONE: ( )

(if spouse - a phone number other than home)

INCOMPLETE INSURANCE INFORMATION MAY RESULT IN CLAIM DENIAL BY THE PAYER!

4 ***PRIMARY INSURANCE COMPANY:***

ID / POLICY NUMBER: ______ GROUP NUMBER: ______

NAME OF SUBSCRIBER / INSURED: ______ RELATIONSHIP: ______

DATE OF BIRTH: ______ SOCIAL SECURITY NUMBER: ______

EMPLOYER NAME: ______ PHONE NO: ( )

5 ***SECONDARY INSURANCE COMPANY:***

ID / POLICY NUMBER: ______ GROUP NUMBER: ______

NAME OF SUBSCRIBER / INSURED: ______ RELATIONSHIP: ______

DATE OF BIRTH: ______ SOCIAL SECURITY NUMBER: ______

EMPLOYER NAME: ______ PHONE NO: ( )

6 Primary Language: ______ Interpreter Service Required: _____Yes _____No

7 Advance Directives: Do you have an Advance Healthcare Directive? ______Yes ______No **(If yes, please provide our office with a copy.)**

Would you like information regarding Advance Healthcare Directive? ______Yes ______No

CONSENT AND ASSIGNMENT:

8 **_____INITIAL - CONSENT TO TREAT: I HEREBY REQUEST AND AUTHORIZE SAN DIMAS FAMILY PRACTICE TO PROVIDE AND PERFORM SUCH MEDICAL/SURGICAL CARE, TESTS, PROCEDURES, DRUGS AND OTHER SERVICES AND SUPPLIES AS ARE CONSIDERED NECESSARY OR BENEFICIAL FOR MY HEALTH AND WELL BEING. IT IS UNDERSTOOD THAT THIS CONSENT IS GIVEN IN ADVANCE OF ANY SPECIFIC SERVICE, BUT IS GIVEN IN ORDER THAT SAN DIMAS FAMILY PRACTICE MAY EXERCISE THEIR BEST JUDGMENT AS TO PROPER MEDICAL CARE WHICH MAY BE NECESSARY TO PROTECT MY LIFE AND HEALTH.**

9 **_____INITIAL - ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN DIRECTLY TO SAN DIMAS FAMILY PRACTICE ALL SURGICAL AND/OR MEDICAL BENEFITS IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.**

10 **_____INITIAL - DISCLOSURE OF PHI: I HEREBY AUTHORIZE SAN DIMAS FAMILY PRACTICE TO RECEIVE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME FOR THE PURPOSE OF TREATMENT, PAYMENT, AND OPERATIONS. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT OTHER DISCLOSURES WILL BE MADE ONLY WITH MY WRITTEN AUTHORIZATION, UNLESS OTHERWISE PERMITTED OR REQUIRED BY LAW. A COMPLETE "NOTICE OF PRIVACY PRACTICES' FOR SAN DIMAS FAMILY PRACTICE HAS BEEN OFFERED TO ME.**

11 SIGNATURE: ______ DATE: ______

(F THE PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENTS)

NOTE: Please notify us if any of the above information changes during the course of your treatment.