NEW PATIENT / UPDATE FORM - PLEASE PRINT

Updated:________ Date:________________

________ Marital Status:_________

(office use only) Age:________________

Patient Name____
Last First M.I. Cell/Pager Number Home Telephone

Address ____
Number Apt. # City State Zip

____
Social Security Number Driver's License Number Birthdate

Patient Employer ____
Name Occupation Work hours Business Telephone

Business Address ____
Number City State Zip

Policy Holder / Insured ____
Name Relationship Birthdate Home Telephone

Address ____
Number Apt. # City State Zip

Insured Employer ____
Name Occupation Business Telephone

Business Address ____
Number City State Zip

In Case of Emergency ____
Name Relationship Home Telephone

How did you find out about our office (**PLEASE SELECT ONLY ONE OF THE FOLLOWING**)

Doctor (name)______________________ Friend / Relative (name)______________________ Phone Book____________

Hospital______________ Insurance Book_______________ Other (please specify)______________________________

I plan to make payment of my medical expenses as follows:

( ) Cash / Check / Credit Card ( ) Medi-Care ( ) Medi-Cal

Insurance Name:______________________Phone Number_________________Certificate Number_____________________

PCP Name & Phone Number:____ Co-Payment________________

I authorize the release of any medical information necessary to process my claim with my insurance company. It is agreed that payment will be made within 30 days of the date(s) of service and will not be delayed because of any insurance coverage issues. I hereby authorize my insurance company to pay directly to Aronson & Rosenthal, M.D., Inc., the benefits of any payable for service(s) rendered. **I understand that I am responsible for all laboratory costs incurred should my insurance not be contracted with the laboratories utilized by this office. I further understand that failure to notify the office 24 hours prior to a scheduled appointment will result in a $25.00 administrative fee**. I have read and fully comprehend the above agreement.

______________________________ ______________________________
Patient Signature Signature of Responsible Party