

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