PATIENT INFORMATION FORM – PACIFIC SHORES MEDICAL GROUP

PATIENT'S NAME: MS. MRS. MR. _____ MALE FEMALE S M D W

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

EMPLOYED: FULL-TIME PART-TIME RETIRED STUDENT: F / P TIME DOB: _____/_____/_____

DRIVER'S LICENSE #:_____ SOCIAL SEC #:_____

EMPLOYER:_____ TITLE/POSITION:_____ PHONE:(____) _____

ADDRESS:_____ CITY:_____ STATE_____ ZIP:_____

REFERRED BY:_____

EMERGENCY INFORMATION (Next of Kin)

NAME:_____ RELATIONSHIP:_____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

ADDRESS:_____ CITY:_____ STATE_____ ZIP:_____

PRIMARY INSURANCEINFORMATION	SECONDARY INSURANCE INFORMATION
INS. CO. NAME:_____	INS. CO. NAME:_____
BILLING ADDRESS:_____	BILLING ADDRESS:_____
INS. CO. PHONE:_____	INS. CO. PHONE:_____
IDENTIFICATION #: _____	IDENTIFICATION #: _____
GROUP POLICY #:_____	GROUP POLICY #:_____
NAME OF INSURED:_____ DOB:____/____/____	NAME OF INSURED:_____ DOB:____/____/____
INSURED SOC. SEC.#:_____	INSURED SOC. SEC.#:_____
RELATIONSHIP TO PATIENT:_____	RELATIONSHIP TO PATIENT:_____

PRESCRIPTION BENEFIT INFORMATION

RX BIN #_____ GROUP #:_____ ID#_____

CARDHOLDER:_____ SOCIAL SEC. #:_____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS: I hereby authorize Pacific Shores Medical Group, Inc. to perform such services which in their medical judgment are necessary for the welfare of the patient identified above. I hereby authorize Pacific Shores Medical Group, Inc. to furnish information to insurance carriers concerning this illness and/or injury. I thereby irrevocably assign all benefits, including major benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of litigation to collect an overdue account, the prevailing party shall be entitled to attorney fees.

_____ _____/_____/_____ _____ _____/_____/_____

PATIENT SIGNATURE DATE INSURED SIGNATURE DATE

Account Number:

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HB 9/11/09 AL