NEW PATIENT FORM **DATE:** _____

PATIENT INFORMATION

18111 Brookhurst St. Suite 2600
Fountain Valley, CA 92709
(714) 200-1010
Fax: (714)200-1299

FIRST NAME	INITIAL	LAST	AGE
			S M W D
DATE OF BIRTH	MALE/FEMALE		MARITAL STATUS
		( ) -	
SOCIAL SECURITY NUMBER		PHONE NUMBER	EMAIL ADDRESS
HOME ADDRESS		CITY	ZIP CODE
PATIENT EMPLOYED BY			OCCUPATION
		( ) -	
EMPLOYER ADDRESS		PHONE NUMBER	
NAME OF SPOUCE OR PARENT		SPOUSE OR PARENT EMPLOYMENT	OCCUPATION
		( ) -	
BUSINESS ADDRESS		PHONE NUMBER	

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE	GROUP NUMBER	MEMBER I.D. NUMBER
INSURED NAME		
SECONDARY INSURANCE IF ANY	GROUP NUMBER	MEMBER I.D. NUMBER
INSURED NAME		
		( ) -
NAME & ADDRESS OF NEAREST FRIEND OR RELATIVE		PHONE NUMBER
		( ) -
REFERRED BY	ADDRESS	PHONE NUMBER

ALL SERVICES PROVIDED AT THE TIME OF VISIT ARE RESPONSIBILITY OF THE PATIENT. AS A COURTESY WE BILL YOUR INSURANCE. IN DOING SO, ALL NECESSARY INSURANCE FORMS AND OR CARDS MUST BE PRESENTED AT THE TIME OF YOUR FIRST VISIT. IF AFTER THIRTY (30) DAYS FROM BILLING YOU INSURANCE, NO PAYMENT OR EXPLANATION HAS BEEN RECEIVED, THE PATIENT IS THEN RESPONSIBLE FOR NOT ONLY MAKING REASONABLE PAYMENTS ON ACCOUNT, BUT ALSO IN CONTACTING THEIR INSURANCE COMPANY TO SEE WHY PAYMENT HAS NOT BEEN RECEIVED. THIS IS THE POLICY OF OUR OFFICE. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.

DATE: _____ **SIGNATURE:** _____