Referring Physician:______________________

Patient's Last Name______________________First Name______________________

Address______________________City,State,Zip______________________

Phone numbers (home)______________________ (work)______________________

(cell)______________________ (pgr)______________________

Birthdate______________________ Age ____________ Sex: Female or Male

SS# ______________________ Marital Status: S - M - D - W

Employer______________________Occupation______________________

Address______________________City,State,Zip______________________

Name and Phone Number in case of emergency ______________________

Insurance Coverage: MEDI-CAL / MEDICARE / HMO / PPO

Primary Insurance Name ______________________ Please provide your insurance card

Sponsor's Name______________________SS#______________________ DOB______________________

Secondary Insurance Name______________________

Sponsor's Name______________________SS#______________________DOB______________________

Spouse's Name ______________________ SS# ______________________

Spouse's Employer ______________________ Phone #______________________

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father's Name ______________________ Phone # (if different)______________________

Address (if different) ______________________ City, State, Zip ______________________

Employer's Name ______________________ Wk # ______________________

Employer's Address ______________________ City, State, Zip______________________

Mother's Name ______________________ Phone # (if different)______________________

Address (if different) ______________________ City, State, Zip ______________________

Employer's Name ______________________ Wk # ______________________

To expedite my insurance claim and treatment, I authorize ALBERT MC CLAIN, M.D. to release to insurance companies, government agencies, other physicians or hospitals, any information needed regarding my present illness or injury or subsequent treatment. I hereby assign to ALBERT MCCLAIN, M.D. all insurance benefits to which I am entitled for services performed by him during my illness.

I assume and agree to pay ALBERT MC CLAIN, M.D. for all charges not paid by my insurance company as a result of this assignment.

Date ______________________ Sign Here ______________________

If a minor, must be signed by parent or guardian