PATIENT INFORMATION SHEET

Name _____ Date _____ Phone _____

Birth Date _____ Age _____ S ____ M ___ D ____ Sep _____ Phone _____

Sex: Male _____ Female _____

Home Address _____ City _____ Zip _____

Social Security # _____ Driver's License _____

If Child, Parent's Name _____

Patient's Employer (or Insured's Employer) _____

Occupation _____ Phone _____

Address _____ City _____ Zip _____

Spouse's Name _____ Social Security # _____

Spouse's Employer _____ Insured's Birth Date _____

Occupation _____ Phone _____

Address _____ City _____ Zip _____

Responsible Party Self _____ Husband _____ Father _____ Mother _____

Nearest Relative _____

Address _____ City _____ Zip _____

Referred by _____

Insurance

___ Blue Cross ___ Medicare ___ Medical

___ Other Insurance (Name and address) _____

_____

I HEREBY AUTHORIZE ANAHEIM SURGICAL ASSOCIATES MEDICAL GROUP TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS AND I HEREBY IRREVOCABLY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR MEDICAL SERVICE RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES WHETHER OR NOT COVERED BY INSURANCE.

_____

INSURED SIGNATURE