SANTA BARBARA INTERNAL MEDICINE GROUP, INC.

PATIENT'S INFORMATION

PATIENT'S NAME _____ AGE ____ SEX (M/F) _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ CELL PHONE # ( ) _____

ADDRESS _____ HOME PHONE # ( ) _____

CITY/STATE _____ ZIP CODE _____ WORK PHONE # ( ) _____

EMPLOYER _____ SPOUSE'S NAME _____ E – MAIL _____

PERSON RESPONSIBLE FOR PAYMENT – OTHER THAN PATIENT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ SOCIAL SECURITY # _____

CITY/STATE _____ ZIP CODE _____ HOME PHONE # ( ) _____

NOTIFY IN CASE OF EMERGENCY WORK PHONE # ( ) _____

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE # ( ) _____

IS THIS WORK RELATED? _____ DATE OF INJURY _____ EMPLOYER _____

WORK COMP CLAIM # _____ ADJUSTER _____ PHONE _____

PRIMARY INSURANCE _____ NAME OF INSURED _____

INSURANCE ADDRESS _____ INSURANCE PHONE ( ) _____

PLAN OR POLICY # _____ SUBSCRIBER ID# _____ DATE OF BIRTH _____

INSURED PARY EMPLOYER _____ INSURED RELATION TO PATIENT _____

SECONDARY INSURANCE _____ NAME OF INSURED _____

INSURANCE ADDRESS _____ INSURANCE PHONE ( ) _____

PLAN OR POLICY # _____ SUBSCRIBER ID# _____ DATE OF BIRTH _____

INSURED PARTY EMPLOYER _____ INSURED RELATION TO PATIENT _____

FINANCIAL RESPONSIBILITY

We will bill your insurance carrier, but you are responsible for co-pays, deductibles and all non-covered services. Co-pays are due at the time of service. Patients are always financially responsible, regardless of insurance coverage. A $15.00 charge will be due for any returned checks.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Your signature authorizes the release of medical information to your insurance company.

Your signature verifies that you have read and agreed to these terms.

SIGNATURE _____ **DATE** _____