My Family Medical Group

5475 Walnut Ave
Chino, CA 91710
(909) 591-6446

PATIENT INFORMATION SHEET (ADULT)

PATIENT NAME: LAST FIRST MIDDLE INITIAL ☐ Mr. ☐ Mrs. ☐ Ms.		DATE OF BIRTH:
HOME ADDRESS:		
CITY: STATE: ZIP:	EMPLOYER:	EMPLOYER'S PHONE:
HOME PHONE: MOBILE PHONE:	OCCUPATION:	YEARS EMPLOYED:
HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS AND OTHER IMPORTANT MESSAGES FROM YOUR HEALTHCARE PROVIDER? ☐ HOME PHONE / VOICE MAIL ☐ MOBILE PHONE / VOICE MAIL (TEXT MESSAGES WHEN AVAIL.)	EMAIL: SOC. SEC. NO: DRIVER'S LICENSE:	
SEX: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	REFERRED BY:	
SPOUSE'S NAME: LAST FIRST MIDDLE INITIAL	DATE OF BIRTH:	SOC. SEC. NO:
SPOUSE'S EMPLOYER:	YEARS EMPLOYED:	BUS. PHONE:
CHILDREN LIVING AT HOME: (names & birth dates)		
NAME OF PERSON NOT LIVING WITH PATIENT TO CONTACT FOR EMERGENCY:		PHONE:

INSURANCE

PRIMARY INSURANCE CARRIER NAME:	POLICY ID#:	GROUP #:
INSURED'S NAME: LAST FIRST MIDDLE INITIAL		
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:	
SECONDARY INSURANCE CARRIER NAME:	POLICY ID #:	GROUP #:
INSURED'S NAME: LAST FIRST MIDDLE INITIAL		
EMPLOYER:	PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
SOCIAL SECURITY # OF INSURED:	EMPLOYER PHONE:	

PATIENT ELIGIBILITY WAIVER

I HEREBY ATTEST THAT I AM AN ELIGIBLE MEMBER OF THE HEALTH PLAN NOTED ABOVE. I AGREE THAT SHOULD IT BE DETERMINED THAT I AM INELIGIBLE FOR SERVICES RENDERED BY MY FAMILY MEDICAL GROUP OR BY ANOTHER FACILITY OR PHYSICIAN AS THE RESULT OF A MY FAMILY MEDICAL GROUP PRIMARY CARE DIRECT REFERRAL, I WILL BE RESPONSIBLE FOR PAYMENT TO MY FAMILY MEDICAL GROUP OR ITS AGENT FOR THOSE SERVICES DEEMED INELIGIBLE OR NOT COVERED.
I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANIES. I AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN.
I AUTHORIZE THIS PRACTICE TO ACT AS MY AGENT TO HELP ME TO SECURE PAYMENT FROM MY INSURANCE COMPANIES.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

In order to control costs of billing we request charges for office visits and/or co-payments be paid at the conclusion of each visit.

Signed: _____ Date: _____