

PATIENT INTAKE INFORMATION

CONFIDENTIAL INFORMATION FOR OUR FILES, UPDATED ANNUALLY

Today's Date	Person Taking Info.	Number
_____	_____	_____
Last Name	First	M.I.
_____	_____	_____
Patient Address	Home Phone	_____
_____	Work Phone	_____
City, State, Zip	Phone Other	_____
_____	Patient Fax	_____
Date of Birth	Gender:	_____
_____	Dominant Hand:	_____
Soc. Sec #	Patient Email	_____
_____	_____	_____
Employer	Drivers License #	_____
_____	Family Doctor	_____
Referred By	_____	_____
_____	Region injured	_____
Date of Injury	Initial Diagnosis	_____
_____	_____	_____

In Case of an Emergency Please Contact: _____ Phone _____
Relationship: _____ Address: _____

RESPONSIBLE PARTY INFORMATION (SELF, SPOUSE, PARENT, LEGAL GUARDIAN):

RESPONSIBLE PARTY	_____
ADDRESS	_____
HOME PHONE	_____
WORK PHONE	_____
PHONE OTHER	_____
EMPLOYER	_____

INSURANCE INFORMATION:

INSURANCE COVERAGE TYPE Work Comp Private Medicare Cash Other

PRIMARY INS CARRIER	_____	
GROUP/POLICY	_____	
INSURED	_____	
ADDRESS	_____	
DOB	SS#	PHONE
_____	_____	_____

SECONDARY INS CARRIER	_____	
GROUP/POLICY	_____	
INSURED	_____	
ADDRESS	_____	
DOB	SS#	PHONE
_____	_____	_____

FINANCIAL AGREEMENT AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to include Major Medical benefits to which I am entitled, including private insurance and any other health plans to: GREG M. BALOURDAS, M.D.. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by said insurance. Further, I understand that I am responsible for payment of all reasonable collection fees and any associated legal costs incurred in the collection of any past due account balance. I hereby authorize assignee to release all information necessary to secure the payment of said benefits.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. 800-633-2322
www.mbc.ca.gov

Signed: _____ Dated: _____

Parent or Guardian