

9404 Genesee Ave., #310
La Jolla, CA, 92037
Phone (858) 677-9700 • FAX (858) 455-7101



ASSIGNED ACCT # _____

TODAY'S DATE _____

Welcome to our office. The following information is considered confidential.

MARITAL STATUS: Single Married Widowed Separated Divorced

SEX: Male Female SSN: _____ Driver's License # _____

Name: _____ Date of Birth: __/__/____

Person legally responsible (Parent/Guardian if minor) _____

Street/Apt: _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email address _____ May we send info Yes No

WORK: Employer _____ Occupation _____

Address: _____ Work Phone _____

City _____ State _____ Zip _____

SPOUSE INFO: Name: _____

Employer: _____

Work Address: _____

City _____ State _____ Zip _____

Person to contact in case of emergency:

Name: _____ Relationship _____

Phone: _____ Home Work Cell

HOW DID YOU HEAR ABOUT OUR FACILITY? _____

PHYSICIAN INFORMATION

Referring Physician _____ Phone # _____

Address _____

Family Physician _____ Phone # _____

Address _____

PAYMENT: CASH INSURANCE WORK COMP AUTO ACCIDENT LIEN

Insurance Company Name: _____

Address _____ City _____ ST _____ Zip _____

Policy # _____ Group # _____

Adjuster Name _____ Phone # _____

**** IT IS THE PATIENT'S RESPONSIBILITY TO MAKE SURE THAT ALL PRIOR AUTHORIZATIONS THAT ARE NEEDED ARE CURRENT AND UP TO DATE, OTHERWISE YOU WILL BE RESPONSIBLE FOR TOTAL AMOUNT OF THE BILL.**