

4150 REGENTS PARK ROW #345
LA JOLLA, CA, 92037
(858)677-9700 • FAX (858)677-9770



ASSIGNED ACCT # _____
TODAY'S DATE _____

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

MARITAL STATUS: Single Married 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 _____

**Please send a copy of my progress report to my family physician Yes No

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.**

