

NEW PATIENT / UPDATE FORM - PLEASE PRINT

Updated: _____

Date: _____

(Office use only)

Marital Status: _____

Age: _____

Patient Name _____
 Last First M.I. Pager/Cell Number Home Telephone

Address _____
 Number Apt. # City State Zip

Social Security Number Driver's License Number Birthdate

Employer _____
 Name Occupation Business Telephone

Business Address _____
 Number City State Zip

Spouse and/or Responsible Party _____
 Name Relationship Birthdate Home Telephone

Address _____
 Number Apt. # City State Zip

Spouse's Employer _____
 Name Occupation Business Telephone

Business Address _____
 Number City State Zip

In Case of Emergency _____
 Name Relationship Home Telephone

How did you find out about our office (Please select only one of the following):

Doctor (name): _____ Friend/Relative: _____ Insurance Directory: _____

Hospital: _____ Other (please specify): _____

I plan to make payment of my medical expenses as follows:

____ Cash / Check / Credit Card ____ Medical Insurance Plan ____ Medi-Cal ____ Medi-Care

PCP Name & Phone Number: _____

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Aronson & Rosenthal, M.D., Inc. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or related to Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice – I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medial information, I agree to the disclosures named in the notice: _____

 Patient Signature

 Signature of Responsible Party