LOS PALOS GASTROENTEROLOGY SPECIALISTS INC.

SALINAS LOCATION: 658 E ROMIE LANE, SALINAS, CA 93901. PH: 831-424-8888 FX: 831-424-8889
WATSONVILLE / FREEDOM: 243 GREEN VALLEY RD STE E, FREEDOM, CA 95019. PH: 831-722-8807 FX: 831-722-8809

CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

SSN#: _____-_____-_____ SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH#: _____ OTHER PH#: _____ EMAIL ADDRESS: _____

RACE: CAUCASIAN
HISPANIC
AFRICAN AMERICAN
OTHER: _____

ETHNICITY: HISPANIC or LATINO
NON HISPANIC or LATINO
OTHER

LANGUAGE SPOKEN: _____

EMPLOYER: _____ OCCUPATION: _____

REF/PRIMARY CARE PHYSICIAN: _____ TELEPHONE#: _____

SPOUSE/PARENT NAME: _____

DOB: _____ SSN#: _____ OTHER PHONE: _____

EMERGENCY CONTACT: _____

PHONE #: _____ RELATIONSHIP: _____

PREFERRED PHARMACY: _____ PHONE#: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ CARD COPIED? YES NO

SUBSCRIBER and DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ CARD COPIED? YES NO

SUBSCRIBER and DOB: _____ RELATIONSHIP TO PATIENT: _____

IF LESS THAN 18 YEARS OF AGE:

FATHER'S NAME: _____ PHONE#: _____

MOTHER'S NAME: _____ PHONE#: _____

I HAVE READ THE FINANCIAL POLICY AND AGREE WITH THE TERMS SET FORTH IN THAT POLICY. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY LOS PALOS GASTROENTEROLOGY SPECIALISTS INC., AND AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO LOS PALOS GASTROENTEROLOGY SPECIALISTS INC., SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. I AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT. I AUTHORIZE LOS PALOS GASTROENTEROLOGY SPECIALISTS INC., TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

SIGNED: _____ DATE: _____

INFO TAKEN BY: _____