TARZANA ENDOCRINE AND MEDICAL GROUP

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PATIENT INFORMATION: PLEASE PRINT, MANDATORY * **ACCOUNT #** _____

ALL INFORMATION IS REQUESTED PRIOR TO THE PHYSICIAN SEEING YOU.

*PATIENT NAME: _____ Date: ___/___/___
Last First Initial

*DATE OF BIRTH: ___/___/___ AGE: _____ SEX ☐ M ☐ F Race: _____ Ethnicity: _____ Language: _____

*HOMEADDRESS: _____
Street City State Zip

MAILING ADDRESS: _____
Street City State Zip

IF YOU HAVE A CALL BLOCKING SERVICE ON YOUR PHONE LINES, YOUR CALL WILL NOT BE RETURNED. AN OPEN PHONE NUMBER IS REQUIRED.

HOME PHONE: (___) _____ CELL PHONE: (___) _____ E-MAIL: _____

*SOCIAL SECURITY #: _____ *DRIVER'S LICENSE #: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER MAIDEN NAME: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ PHONE: (___) _____
Street City State Zip

SCHOOL NAME: _____ FULL TIME ☐ PART TIME ☐

SCHOOL ADDRESS: _____
Street City State Zip

INSURANCE INFORMATION: **PLEASE PROVIDE THE RECEPTIONIST WITH A GOVERNMENT PHOTO ID AND ALL INSURANCE CARDS TO BE COPIED.**

*PRIMARY INSURANCE COMPANY: _____

INSURANCE CO. ADDRESS: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SOC. SEC. #: _____

BIRTHDATE: ___/___/___ RELATION TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

*GROUP #: _____ *SUBSCRIBER: _____ ID #: _____ *EFFECTIVE DATE: _____

INSURANCE COMPANY PHONE #: (___) _____ CO-PAY AMOUNT: $ _____

SECONDARY INSURANCE COMPANY: _____

*SECONDARY INSURANCE COMPANY: _____

INSURANCE CO. ADDRESS: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SOC. SEC. #: _____

BIRTHDATE: ___/___/___ RELATION TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

*GROUP #: _____ *SUBSCRIBER: _____ ID #: _____ *EFFECTIVE DATE: _____

INSURANCE COMPANY PHONE #: (___) _____ CO-PAY AMOUNT: $ _____

SPOUSE INFORMATION OR RESPONSIBLE PARTY:

SPOUSE NAME: _____ _____ _____
Last First Initial

DATE OF BIRTH: ____/____/____ AGE: _____ SEX ☐ M ☐ F HOME PHONE: (_____) _____

HOME ADDRESS: _____ _____ _____ _____
Street City State Zip

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

EMPLOYER: _____ WORK PHONE: (_____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____ _____ _____ RELATION TO PATIENT: _____
Last First Initial

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____

I HEREBY GIVE CONSENT FOR TREATMENT BY TARZANA ENDOCRINE AND MEDICAL GROUP. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES PERFORMED ON MY BEHALF IF NOT COVERED BY MY INSURANCE COMPANY.

_____ _____
PATIENT SIGNATURE PARENT / GUARDIAN

AUTHORIZATION AND RELEASE:

ALL CO-PAYMENTS, DEDUCTIBLES & NON-COVERED SERVICES ARE DUE AT THE TIME OF YOUR SERVICE.

I HEREBY AUTHORIZE PAYMENT TO THE PROVIDER FOR MEDICAL AND/OR SURGICAL BENEFITS.

I HEREBY AUTHORIZE PROVIDER TO RELEASE ALL INFORMATION NECESSARY, ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT, TO SECURE PAYMENT FOR SERVICES.

THE FOLLOWING POLICY HAS BECOME NECESSARY BECAUSE SOME HEALTH INSURANCE COMPANIES ARE DENYING LEGITIMATE CHARGES AS A COST CONTAINMENT MANEUVER. WE WILL CONTINUE TO BILL INSURANCE FOR YOUR CONVENIENCE. IF YOUR HEALTH INSURANCE HAS NOT PAID IN 30 (THIRTY) DAYS, YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OWED.

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES PERFORMED ON MY BEHALF IF NOT COVERED FULLY BY THE INSURANCE. I UNDERSTAND THE PATIENT BALANCE IS DUE WITHIN TEN (10) DAYS OF THE BILLED STATEMENT. I ACCEPT FINANCIAL RESPONSIBILITY I WILL BE BILLED AN ADDITIONAL $2.50 FOR EACH ADDITIONAL STATEMENT ON PAST DUE BALANCES.

CANCELLATION POLICY, EFFECTIVE NOVEMBER 1, 2011:
IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE US 24-HOUR NOTICE, OR YOU WILL BE SUBJECT TO A MISSED APPOINTMENT FEE.

PATIENT SIGNATURE _____ DATE _____

PARENT / GUARDIAN SIGNATURE _____ DATE _____