PACIFIC ARTHRITIS
CARE CENTER

¤ 5230 Pacific Concourse Drive, Suite 100
Los Angeles, CA 90045

¤ 1260 Fifteenth Street, Suite 1400
Santa Monica, CA 90404

Patient Registration – Confidential

Patient Name: Date of Birth: Today's Date:

Street Address: City, State: Zip:

Phone #: SS#:

Referring Physician: Address/Phone:

E-mail:

Employer: Occupation:

Employer Address: Work/Cell Phone #:

Marital Status: S ☐ M ☐ W ☐ D ☐ Sep ☐
Please circle one

Spouse's Name: Date of Birth:

Employer/Occupation: Phone #:

Emergency Contact Name: Relation:

Phone #:

Address:

Billing Information/Responsible Party – Payment required at time of service unless prior arrangements made

Billing Name (if other than patient): Relation:

Billing Address:

Insurance Information

Primary Insurance Company: Phone #:

Address:

Name of Insured: Relation to Patient:

Additional Insurance Company: Phone #:

Address:

Name of Insured: Relation to Patient:

Medicare #: Medicaid #:

Is your condition employment related?: Y ☐ N ☐ If yes, date of injury:

Is your condition accident related?: Y ☐ N ☐ If yes, date of injury:

Name of Attorney (if applicable):

Address: City: Phone #:

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Pacific Arthritis Care Center for services rendered by him in person and under his supervision. I understand that I am financially responsible for any balance not covered by my insurance plan.

Initial/Date: _____/_____

Authorization to Release Information

I hereby authorize the Pacific Arthritis Care Center to release any medical or incidental information that may be necessary for either medical care or in processing information for medical benefits.

Initial/Date: _____/_____

Medicare/Medicaid

I certify that the information given me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Initial/Date: _____/_____

A photocopy of these assignments shall be valid as the original.

Patient Name (please print):_____ Date:_____

Signature of Insured:_____Date:_____