

# PACIFIC ARTHRITIS CARE CENTER

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

☐ 1260 Fifteenth Street, Suite 1414  
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:	
Employer:	Occupation:	
Employer Address:	Work/Cell Phone #:	
Marital Status:	S    M    W    D	Sep
<small>Please circle one</small>		
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: \_\_\_\_\_