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:

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 Medical Center, Inc. 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:_____