



# FAMILY MEDICAL CENTER

**Dr. J. Patel, M.D.**  
30271 Golden Lantern, Suite C  
Laguna Niguel, CA 92677  
Tel: (949) 363-5322

## PATIENT INFORMATION

PATIENT'S NAME		MALE FEMALE	MARITAL STATUS S   M   DIV   SEP   WID			DATE OF BIRTH / /	DRIVERS LIC. NO.
STREET ADDRESS		<input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY		CITY AND STATE		ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER ( <i>Father's Employer If Minor</i> )		OCCUPATION (Indicate if Student)		HOW LONG EMPLOYED?		SOCIAL SECURITY NO.	
EMPLOYER'S STREET ADDRESS			CITY / STATE / ZIP CODE			BUSINESS PHONE NO.	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP TO PATIENT: TEL: ( )			FAX: WORK ( ) HOME ( )		
SPOUSE'S NAME ( <i>Mother's Name If Minor</i> )		FATHER'S NAME IF MINOR		E-MAIL: WORK HOME			
SPOUSE'S EMPLOYER ( <i>Mother's Employer If Minor</i> )		OCCUPATION (Indicate if Student)		HOW LONG EMPLOYED?		BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS				CITY AND STATE		ZIP CODE	
WHO REFERRED YOU TO THIS PRACTICE? (Please Circle)						PREVIOUS PHYSICIAN'S NAME	
Relative Friend Yellow Pages Insurance Book Pass By Walk-in Attorney Employer Hospital Physician Visitor Other							

## INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		HOME PHONE NO.
STREET ADDRESS, CITY, STATE AND ZIP CODE		
<input type="checkbox"/> COMPANY NAME AND ADDRESS		
NAME OF POLICYHOLDER	CERTIFICATE NO.	GROUP NO.
<input type="checkbox"/> MEDICARE	MEDICARE NO.	

*In order to control our cost of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.*

Method of Payment:  Cash  Check  VISA  Mastercard  Discover  Other \_\_\_\_\_

**AUTHORIZATION:** I hereby authorize Family Medical Center or the physicians indicated above to furnish information to insurance carrier concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I agree to assume total responsibility in notifying any changes of my medical insurance coverage or change of address to Family Medical Center as soon as possible. I understand that I am financially responsible for all charges whether or not covered by insurance. I also understand that if I do not pay as services are rendered, a service charge of 3/4% per month will be added each month if there is an outstanding balance. Should this account become delinquent I understand that I am responsible for any or all legal representative, court cost and collection charges involved as a result of any collection activity.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

*I confirm that the above details are unchanged and that I agree to abide by the terms as before.*

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_