Los Alamitos
CARDIOVASCULAR
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This form has expired, please click here for updated form.

PATIENT INFORMATION:

Last Name:ome Phone #: _____ _____

First Name: _____ M.I. _____ Work Phone #: _____

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Social Security #: _____

Zip Code: _____ Sex (M/F): _____ Marital Status: _____

Driver License #: _____ Occupation: _____

Employer: _____ Who may we thank for referring you to this office?: _____

Address: _____ _____

Are you allergic to any medications? ☐ NO ☐ YES

If yes, which medications? _____

Contact in case of
EMERGENCY: _____ Phone #: _____

Relationship: _____

GUARANTOR / PARENT / INSURED INFORMATION (SEND BILL TO):

Name: _____ Social Security #: _____

Employer: _____ Phone #: _____

Address: _____ Relationship to Patient: _____

PRIMARY INSURANCE CARRIED BY PATIENT

Insurance Co. Name: _____

Billing Address: _____

_____

Group or Policy #: _____

Cert. or Member #: _____

Local Union #: _____

Name of Insured: _____

Insured's DOB: _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____

Billing Address: _____

_____

Group or Policy #: _____

Cert. or Member #: _____

Local Union #: _____

Name of Insured: _____

Insured's DOB: _____

I hereby assign all medical / or surgical benefits to include major medical benefits to which I am entitled, including Medicare and all other insurance to Los Alamitos Internal Medical Group, Inc. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all the charges incurred, including but not limited to copayments and annual deductible. I am also responsible for the charges denied by either Medicare and or all other insurance. I hereby consent to and authorize all treatment and medical services by the physician(s) and staff of this office as they deem necessary. I authorize the release of any information regarding my history, treatment, findings, and other clinical studies and diagnosis that this office deems necessary.

PATIENT SIGNATURE _____ INSURED SIGNATURE _____

PATIENT OR GUARDIAN SIGNATURE OF MINOR _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. DATE _____