

NEW PATIENT INFORMATION

MR. MRS. MISS MS. _____ DATE _____

HOME PHONE _____ WORK PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX: M F DATE OF BIRTH ____/____/____

MARITAL STATUS: SINGLE DIVORCED MARRIED WIDOWED

SOCIAL SECURITY NUMBER _____ - _____ - _____

PATIENT'S EMPLOYER _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

OCCUPATION _____

How did you hear about our office?

Another patient (please give patient name) _____

Other source _____

INSURANCE: Please list the subscriber of the policy if other than patient.

PRIMARY _____ **POLICY #** _____
Address _____ **GROUP #** _____
Subscriber _____

SECONDARY _____ **POLICY #** _____
Address _____ **GROUP #** _____

ASSIGNMENT OF BENEFITS

I HEARBY AUTHORIZE PAYMENT of medical benefits per appropriate assignment(s) above to **Internal Medicine/Richard Gobao M.D., LLC**, or any private practioners rendering services, not to exceed the balance due of any aforementioned providers' regular charges for this period. I understand that I am financially responsible for charges not covered by this authorization.

RELEASE OF INFORMATION

I authorize release of this medical record, any related studies, any other medical information to any doctor to whom I am referred, my legal counsel, and to the applicable third-party payor.

INSURED PERSON _____ DATE _____

EMERGENCY, PLEASE CALL _____ PHONE _____

RELATIONSHIP _____