WALK-IN MEDICAL CARE

NEW PATIENT INFORMATION RECORD *(Please Print or Write Legibly)*

Has this office ever rendered treatment to any member of your family? ☐ YES ☐ NO

Date _____

Patient _____ Birth Date _____ Age _____
First Name Middle Last Name

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Sex: ☐ Male ☐ Female

_____ Rent ☐ Owns ☐

Address _____ Home Phone ( ) _____

City _____ Zip _____ Social Security # _____

Employed By _____ Occupation _____

Business Address _____
Street City

Business Phone _____ Driver License # _____

Wife or Husband _____ Social Security # _____ Birth Date _____
First Name Middle Name

Employed By _____ Occupation _____

Business Address _____
Street City

Business Phone _____ Driver License # _____

Reason for Visit _____

Friend to Contact in Case of Emergency

Name _____
Phone

Address _____
City

INSURANCE INFORMATION

Do you have group medical insurance? ☐ Yes ☐ No

Insurance Co. (1) _____

Address: _____

_____ Zip _____

Member Certificate No.: _____

Group No.: _____

Insured's Name: _____

Auto Insurance? *(Only for Auto Accident Cases)*

Insurance Co. (2) _____

Address: _____

_____ Zip _____

Member Certificate No.: _____

Group No.: _____

Insured's Name: _____

Medicare ☐ Yes ☐ No Number: _____

Medi-Cal ☐ Yes ☐ No Number: _____

(PLEASE GIVE YOUR BLUE SHIELD, MEDICARE, MEDI-CAL OR OTHER INSURANCE CARD TO THE RECEPTIONIST!)

RELEASE OF INFORMATION ASSIGNMENT OF BENEFITS

I hereby authorize KAILASH R. DHAMIJA M.D. to disclose when requested by the above named insurance carrier or its representatives any and all information with respect to any illness(es) or injury(ies), medical history, or treatment and copies of all medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby authorize payment directly to KAILASH R. DHAMIJA M.D. of the surgical and/or medical benefits, if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges nor covered by this authorization. I further agree in the event of non-payment, to bear the cost of reasonable legal fees should this be required.

Date _____ Signature _____
(Patient or Parent, if Minor)