Los Alamitos
CARDIOVASCULAR

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PATIENT INFORMATION

PART 1: CONTACT & PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

☐ MALE ☐ FEMALE	DATE OF BIRTH	MARITAL STATUS

STREET ADDRESS

CITY	STATE	ZIP

HOME PHONE	WORK PHONE	MOBILE PHONE
( )	( )	( )

E-MAIL ADDRESS FOR PATIENT PORTAL

RACE	ETHNICITY	PRIMARY LANGUAGE SPOKEN

YOUR PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN'S PHONE
	( )

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE PHYSICIAN)	REFERRER'S PHONE
	( )

Do you have an Advance Health Care Directive? ☐ YES ☐ NO

EMERGENCY CONTACT

LAST NAME	FIRST NAME	RELATIONSHIP TO YOU

PRIMARY PHONE	MOBILE PHONE
( )	( )

PHARMACY INFORMATION

PRIMARY PHARMACY	PHONE
	( )

STREET ADDRESS	CITY	ZIP

PATIENT EMPLOYER INFO

EMPLOYER NAME	PHONE
	( )

STREET ADDRESS	CITY	ZIP

PART 2 INSURANCE INFO: Continued on reverse side

PART 2: INSURANCE INFORMATION

GUARANTOR/PARENT/INSURED INFORMATION (SEND BILL TO)

LAST NAME	FIRST NAME	
DATE OF BIRTH (MM/DD/YYYY) / /	SOCIAL SECURITY #	RELATIONSHIP
STREET ADDRESS		
CITY	STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )	MOBILE PHONE ( )
EMPLOYER NAME & ADDRESS		EMPLOYER PHONE NUMBER ( )

PRIMARY INSURANCE

COMPANY	PLAN TYPE ☐ PPO ☐ HMO ☐ OTHER _____	
GROUP/POLICY #	CERT. MEMBER #	LOCAL UNION #
BILLING STREET ADDRESS		
CITY	STATE	ZIP

SECONDARY INSURANCE

COMPANY	PLAN TYPE ☐ PPO ☐ HMO ☐ OTHER _____	
GROUP/POLICY #	CERT. MEMBER #	LOCAL UNION #
BILLING STREET ADDRESS		
CITY	STATE	ZIP

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: _____ Date: _____

Insured Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL