ALAMO HILLS MEDICAL GROUP, INC.

2876 SYCAMORE DRIVE, SUITE 101
SIMI VALLEY, CA 93065
OFFICE (805) 527-6424 FAX (805) 522-0115

PATIENT INFORMATION SHEET

PATIENT'S ACCOUNT #	DATE	DRIVER'S LICENSE (IF NOT CA, LIST STATE)	
NAME (LAST, FIRST, M.I.)		HOME TELEPHONE #	CELL TELEPHONE #
ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH		SEX(M/F)	MARITAL STATUS SINGLE____ MARRIED____ DIVORCED ____ WIDOWED ____
WHO REFERRED YOU?	YOUR EMPLOYER	WORK TELEPHONE #	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
SPOUSE NAME			
WHO SHOULD WE CALL IN CASE OF AN EMERGENCY?	RELATIONSHIP / TELEPHONE		
CHILDREN/DOB			

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE.

INSURANCE NAME & ADDRESS		
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY

SECONDARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE.

INSURANCE NAME & ADDRESS		
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NO.

I directly assign all medical benefits to ALAMO HILLS MEDICAL GROUP, INC. (my physician) and understand that I am financially responsible for all charges. I understand that my patient balance is due in full upon receipt of statement and a finance fee of 1.5% (18% APR) per month will be applied to all balances not paid within 30 days from the date of statement. I understand that I may have additional financial responsibility for outside radiology and/or laboratory services. I authorize ALAMO HILLS MEDICAL GROUP, INC. to release any information to my insurance companies when requested by them to secure payment of benefits.

DATE ______________________ SIGNED (Insured or Authorized) ______________________