SAN FRANCISCO PREVENTIVE MEDICAL GROUP

PATIENT INFORMATION FORM

DATE: _____

PATIENT'S NAME: _____ MR. ____ MRS. ____ MS. ____ AGE: _____
(LAST) (FIRST)

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

DATE OF BIRTH: _____ HOME PHONE #: ( ) _____

EMPLOYER: _____ WORK PHONE #: ( ) _____

EMPLOYER'S ADDRESS: _____

OCCUPATION: _____ SOCIAL SECURITY #: _____ - _____ - _____

SPOUSE'S EMPLOYER: _____ WORK PHONE #: ( ) _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

PATIENT'S NEAREST RELATIVE: _____ PHONE #: ( ) _____

PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

DENTIST: _____ DATE OF LAST VISIT: _____

YOUR REFERRAL: _____ PHONE #: ( ) _____

NAME OF MEDICAL INSURANCE: _____

IF PATIENT IS A MINOR, WHO IS FINANCIALLY RESPONSIBLE? _____

WHOM TO CONTACT IN CASE OF EMERGENCY? _____

ACKNOWLEDGEMENT:

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service unless other arrangements have been made with the office in writing. A valid credit card number will be required at the time of scheduling in order to secure an appointment. I understand that a $100.00 fee will be charged if my initial appointment is not cancelled 48 hours in advance, as well as a $25.00 service fee for any returned checks.

_____ _____
PARENT OR GUARDIAN'S SIGNITURE PATIENT'S SIGNATURE

DUE TO OUR BUSY SCHEDULE, WE WOULD APPRECIATE YOUR CALLING-IN TO CANCEL OR RE-SCHEDULE YOUR APPOINTMENT TO GIVE THE TIME SET ASIDE FOR YOU TO PATIENTS WHO ARE WAITING TO SEE THE DOCTOR. THANK YOU.