



**SADDLEBACK**  
MEDICAL GROUP

PHYSICIAN \_\_\_\_\_

**PATIENT INFORMATION**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_  
 SEX  M  F BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ PHONE \_\_\_\_\_  
MO. DAY YEAR  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT \_\_\_\_\_  
 DRIVER'S LICENSE \_\_\_\_\_ ST \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 WHO IS YOUR PRIMARY CARE PHYSICIAN? \_\_\_\_\_ WHAT IS YOUR CO-PAY? \_\_\_\_\_  
 WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
 MAY WE CONTACT YOU AT HOME WITH RESULTS?  YES  NO CELL PHONE \_\_\_\_\_  
 LEAVE A MESSAGE AT YOUR:  HOME  OFFICE  OFFICE VOICE MAIL  OTHER \_\_\_\_\_

**EMERGENCY CONTACT:**

LAST \_\_\_\_\_ FIRST \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**INSURANCE: PRIMARY**

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME \_\_\_\_\_ ID# \_\_\_\_\_ GRP NO. \_\_\_\_\_  
 INSURED NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO. DAY YEAR  
 CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER \_\_\_\_\_

**INSURANCE: SECONDARY**

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME \_\_\_\_\_ ID# \_\_\_\_\_ GRP NO. \_\_\_\_\_  
 INSURED NAME \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MO. DAY YEAR  
 CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER \_\_\_\_\_

**AUTHORIZATION**

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, AND I CONSENT TO ANY MEDICAL OR SURGICAL TREATMENT RENDERED THE PATIENT UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF THE PHYSICIAN.

\_\_\_\_\_  
 SIGNATURE OF PATIENT

**ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED**

I, HEREBY, ASSIGN ALL BENEFITS TO SADDLEBACK MEDICAL GROUP, INC. FOR SERVICES RENDERED TO ME OR SAID MINOR PATIENT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME OR SAID MINOR TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO SADDLEBACK MEDICAL GROUP, INC. AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE GIVEN ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE IN MY BEHALF BY MY INSURANCE COMPANY.

SIGNED, PATIENT (OR PARENT IF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

IF OTHER THAN PARENT, RELATIONSHIP \_\_\_\_\_