HINDS MEDICAL GROUP **2 James Way, Suite 109, Pismo Beach, CA 93449** **805.773.6500**

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PATIENT NAME _____ TODAY'S DATE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

SOCIAL SECURITY# _____ DATE OF BIRTH _____ □ MALE □ FEMALE

MARITAL STATUS: □ MARRIED □ DIVORCED □ WIDOWED □ SINGLE □ SEPARATED **EMPLOYMENT STATUS**: □FULL □RETIRED □SELF EMPLOYED □PART □NONE □ACTIVE MILITARY

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

REFERRING PHYSICIAN _____ PHONE _____

PERSON TO CONTACT FOR EMERGENCIES _____ PHONE _____ (OTHER THAN AT YOUR HOME PHONE)

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PRIMARY INSURANCE _____

INSURED'S NAME _____

RELATIONSHIP TO PATIENT: □ SELF □ CHILD □ SPOUSE □ OTHER **INSURED'S DATE OF BIRTH** _____ □ MALE □ FEMALE

ID# _____ GROUP# _____

SECONDARY INSURANCE _____

INSURED'S NAME _____

RELATIONSHIP TO PATIENT: □ SELF □ CHILD □ SPOUSE □ OTHER **INSURED'S DATE OF BIRTH** _____ □ MALE □ FEMALE

ID# _____ GROUP# _____

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PLEASE LIST ALLERGIES: _____

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AUTHORIZATION / RELEASE OF INFORMATION

I authorize any holder of medical information about me and/or my family to release information to third party payors in order to determine benefits for services provided. I authorize payment by my third party payers directly to Hinds Medical Group. I permit a copy of this authorization to be used as the original. I have verified that Hinds Medical Group is the provider I and/or my family must use for the insurance contract under which I/my family is covered. I understand that if the previous is not true, I am responsible for payment of charges related to services, supplies, products, or equipment provided to me and/or my family.

_____ _____

Signature **Date**

I authorize the physician and staff of Hinds Medical Group to render medical treatment to me and/or my family. Except for medical emergencies, any patient/guardian who refuses to complete and sign this authorization for treatment may be denied service. I have read and agree to the above conditions. I also verify I received a notice titled "The Federal Truth in Lending/Billing Act and Financial Agreement" and agree to all conditions therein.

_____ _____

Signature **Date**