

PATIENT INFORMATION

PH# : (310) 659-8760 Fax#: (310) 673-0951

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THIS SECTION REFERS TO PATIENT ONLY				
NAME	SEX	AGE	D.O.B.	MARITAL STATUS
ADDRESS		S.S. NUMBER		<input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED
CITY	STATE	ZIP	EMPLOYER NAME	
HOME PHONE ()	WORK PHONE ()	ADDRESS		
CALIFORNIA DRIVER'S LICENSE NO.	OCCUPATION	CITY	STATE	ZIP
PREVIOUS DOCTOR	ADDRESS	CITY	ZIP	PHONE ()
NAME OF PERSON TO BE NOTIFIED IN EMERGENCY	ADDRESS	CITY	ZIP	PHONE ()
DO YOU HAVE ANY ALLERGIES TO MEDICATION? EMAIL ADDRESS				
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHICH ONE?				

INSURANCE INFORMATION				
HEALTH PLAN				
ELIGIBILITY VERIFICATION AUTHORIZATION NEEDED <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> PVT. INS. <input type="checkbox"/> MEDI-MEDI <input type="checkbox"/> CASH <input type="checkbox"/> MEDICARE <input type="checkbox"/> W/C <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> P.I.		ACCT NO. _____ EXP. DATE _____		
NAME OF INSURANCE COMPANY PRIMARY		NAME OF INSURANCE COMPANY SECONDARY		
ADDRESS		ADDRESS		
NAME OF INSURED		NAME OF INSURED		
POLICY HOLDER (COMPANY NAME GROUP)	GROUP NO.	POLICY HOLDER (COMPANY NAME GROUP)	GROUP NO.	
POLICY OR CERTIFICATE NO./S.S. NO.	EFFEC. DATE	POLICY OR CERTIFICATE NO./S.S. NO.	EFFEC. DATE	
PATIENT IS: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER (SPECIFY) _____		PATIENT IS: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER (SPECIFY) _____		
<input type="checkbox"/> MEDI-CAL I.D.# _____ <input type="checkbox"/> MEDI-CARE I.D.# _____		CO-INSURANCE HAVE YOU MET YOUR DEDUCTIBLE? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____ <input type="checkbox"/> YES <input type="checkbox"/> NO \$ _____		
REFERRED	ADDRESS	CITY	ZIP	PHONE ()

ACKNOWLEDGEMENT AND AUTHORITY FOR TREATMENT AND PAYMENT

I consent to treatment as necessary or desirable to the patient named above, including but not restricted to whatever drugs, medicine, performance of operations, laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designee.

I further understand that the qualified designee in some cases will be the Assistant to the Physician, also call P.A. An Assistant to the Physician means a person who is a graduate of an approved program of instructions in Health Care and is approved by the Board to perform direct patient care services under the supervision of a Physician.

I also acknowledge full responsibility for such services and agree to pay for them, in full, AT THE TIME OF SERVICES, If payment is not received within sixty (60) days of service, a finance charge of 1 1/2% per month will be applied to the unpaid balance. If the physician must use a collection agency/attorney/or court to collect charges, then I will pay reasonable attorney fees, and costs, incurred in collecting same, regardless of insurance coverage.

I hereby authorize payment directly to DONALD R. HENDERSON, M.D., MPH of the Medical Expenses benefits otherwise payable to me but not exceed my indebtedness to said physician on account of the enclosed charge.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits myself or the party who accepts assignment below.

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the designated physician or supplier for services rendered.

SIGNED _____ DATE _____ SIGNED _____

NOTE: A PHOTO COPY OF THIS IS CONSIDERED AS VALID AS THE ORIGINAL

INSURED'S SIGNATURE _____ SIGNED (PATIENT) _____
 SIGNATURE _____ SIGNED (PATIENT GUARDIAN) _____