ARTHRITIS & OSTEOPOROSIS MEDICAL CENTER

5451 La Palma Ave #25 ☐
La Palma, CA 90623

☐ **2063 S. Atlantic Blvd. #300**
Monterey Park CA 91754

Date_____ (Please Print)

PATIENT INFORMATION

Name_____ Home Phone # ( ) _____
Last Name First Name Middle Initial **OK to leave voice mail? Please check one box ☐yes ☐no**

Address_____ Cell Phone # ( ) _____

City _____ State _____ Zip Code _____ **OK to leave voice mail? Please check one box ☐yes ☐no**

Driver's License # or State ID # _____ Primary contact number ☐ Home ☐ Cell

SS# _____-_____-_____ E-mail _____

Sex ☐M ☐ F Age_____ Birth date_____ Desired method of contact (please check all that apply)

☐Married ☐Widowed ☐Single ☐Voice ☐Text ☐Email

☐Separated ☐Divorced Patient Employer _____

Height _____ Weight _____ Employer Address _____

_____

Referring Physician_____ Occupation _____

Physician Phone # ( ) _____ Employer Phone # ( ) _____

Emergency Contact_____ Phone # ( ) _____

Your relationship to emergency contact _____

From time to time we may ask you if we can take a picture of you to include in your chart, related to the condition you may be treated for, please check one of the boxes below with your desired directive and sign. Thank you.

☐ **Yes I consent** ☐ **No I do not consent**

Patient Signature _____

INSURANCE AUTHORIZATION RELEASE

Please read and complete the following to allow the Arthritis & Osteoporosis Medical Center to submit claims to and receive reimbursement from your insurance for medical services provided. Please note: If the patient is not the insured member, both the patient and the insured member must sign below.

Is the patient the insured? ☐ **Yes** ☐ **No** **If you checked no, please fill out insured information line below**

Insured Name_____ Insured D.O.B. _____ Insured SS#_____

Insurance Carrier:_____ Insurance ID # _____ Group # _____

By signing below, I hereby authorize _____Insurance Company to assign all medical benefits to which I am entitled, and make payment directly to:

Arthritis & Osteoporosis Medical Center
Attn: Accounts Receivable
5451 La Palma Avenue, Suite 25
La Palma, California 90623

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the Arthritis & Osteoporosis Medical Center to release all information necessary to secure payment for medical services rendered.

_____ _____
Patient's Signature Date