Surgical Associates of La Jolla

☐ Paul V.B. Hyde, M.D., F.C.S, F.R.C.S., F.A.C.S.
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PATIENT INFORMATION					
Patient's Last Name:		First Name:		Middle Initial:	
Mailing Address:		City:		State:	Zip:
E-mail Address:					
Home Phone: ( )		Mobile Phone: ( )		Work Phone and Extension: ( )	
Patient DOB:	Age:	Sex:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
Ethnicity: ☐ Hispanic / Latin ☐ Not Hispanic or Latin ☐ Decline to State		Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian / Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Decline to State			
Preferred Language: ☐ English ☐ Other:_____		Social Security Number:		Occupation:	
Primary Care Physician and Phone:		Referring Provider and Phone:			
How Did You Hear About Our Office?		Next of Kin:			

IN CASE OF EMERGENCY			
Name of Emergency Contact Person:	Relationship to Patient:	Home Phone: ( )	Cell Phone: ( )

RESPONSIBLE PARTY (GUARANTOR) *(if patient is spouse, dependent, or student)*			
Guarantor's Last Name:	Guarantor's First Name:	Guarantor's Middle Name:	
Mailing Address:	City:	State:	Zip:

PRIMARY INSURANCE *(please present new insurance card to our office staff)*		
☐ Self-Pay / No Insurance ☐ Patient is the Insured Subscriber	Policy Subscriber's Name *(if not patient)*:	Policy Subscriber's DOB *(if not patient)*:
Name of Primary Insurance:	Primary Insurance Address:	Policy Subscriber's Phone: ( )
Patient's Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		Policy Subscriber's Social Security #:
Subscriber Number:	Group Number:	Specialist Co-Pay: $

SECONDARY INSURANCE *(please present new insurance card to our office staff)*		
☐ Self-Pay / No Insurance ☐ Patient is the Insured Subscriber	Policy Subscriber's Name *(if not patient)*:	Policy Subscriber's DOB *(if not patient)*:
Name of Primary Insurance:	Primary Insurance Address:	Policy Subscriber's Phone: ( )
Patient's Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		Policy Subscriber's Social Security #:
Subscriber Number:	Group Number:	Specialist Co-Pay: $

PHARMACY INFORMATION		
Pharmacy Name:	Pharmacy Location *(address or intersection is okay)*:	Pharmacy Phone: ( )