SALJ Medical Group, Inc. Patient Information

DR. HYDE ☐ **DR. SHERMAN** ☐ **DR. OLSON** ☐ **Date**_____

(PLEASE CIRCLE DOCTOR YOU ARE SEEING)

***PLEASE PRINT** Print

LAST NAME (LEGAL)	**FIRST NAME (LEGAL)**		**MIDDLE INITIAL**
MAILING ADDRESS	**CITY**	**STATE**	**ZIP**
HOME PHONE	**WORK PHONE**		**OTHER PHONE**
SEX M / F	**MARITAL STATUS**	**DATE OF BIRTH**	**SOCIAL SECURITY #** (MANDATORY TO BILL INSURNACE)	**DRIVERS LICENSE**
E-MAIL ADDRESS			
REFERRING PHYSICIAN OR PATIENT	**PHONE #**		
PRIMARY CARE PHYSICIAN	**PHONE #**		
NAME OF SPOUSE	**PHONE #**	**DATE OF BIRTH**	**SOCIAL SECURITY #**
EMERGENCY CONTACT	**PHONE #**		**RELATION**
PRIMARY INSURANCE	**SECONDARY INSURANCE**		
PLEASE CIRCLE ONE **NOT HISPANIC OR LATINO** ☐ **HISPANIC OR LATINO** ☐	**RACE: I.E. CAUCASIAN**	**PRIMARY LANGUAGE**	

I AUTHORIZE SALJ MEDICAL GROUP, INC TO LEAVE A MESSAGE WITH MY FAMILY, OR ON AN ANSWERING DEVICE, REGARDING PERSONAL INFORMATION PERTAINING TO MY MEDICAL CARE OR OFFICE APPOINTMENTS.

☐ **YES** ☐ **NO**

I consent to any medical treatment or physical examination required for myself or the minor named above for whom I am legally responsible. I authorize the release of all medical records for treatment, payment from insurance or other healthcare needs. A copy of this authorization to release medical records is as valid as the original. I understand that Surgical Associates of La Jolla is not contracted with HEALTHNET insurance and I am financially responsible for all fees unpaid by my insurance carrier. Surgical Associates of La Jolla Medical Group, Inc. cannot accept responsibility for any denied claims or for negotiating a settlement on a disputed claim. I understand that I am fully responsible for any and all charges rendered at Surgical Associates of La Jolla Medical Group, Inc. A finance charge of 1.5% will be applied to balances due over 60-days.

I have received a copy of the HIPAA Notice of Privacy Practices Pamphlet. Initial here _____

Signature_____ **Date**_____ Print