After Hours Medical Group

PLEASE TELL US……..WHO REFERRED YOU?? _____

CONFIDENTIAL PATIENT INFORMATION

NAME: _____ DOB: _____ AGE: __ SEX: M/F MARITAL STATUS: _____
HOME: (____) _____-_____ CELL: (____) _____-_____ SSN: _____ DL#: _____
ADDRESS: _____CITY: _____ STATE:___ ZIP: _____
BIRTH PLACE:_____E-MAIL ADDRESS:_____
MAY WE CONTACT YOU BY E-MAIL REGARDING APPOINTMENTS AND EVENTS: _____

IF THE PATIENT IS A DEPENDENT ON SOMEONE ELSES INSURANCE
PLEASE PROVIDE RESPONSIBLE PARTY INFORMATION

NAME: _____ DOB: _____ AGE: __ SEX: M/F MARITAL STATUS: _____
HOME: (____) _____-_____ CELL: (____) _____-_____ SSN: _____ DL#: _____
ADDRESS: _____CITY: _____ STATE:___ ZIP: _____

EMERGENCY CONTACT

NAME: _____ PHONE #: ( ) _____ RELATION: _____

I herby instruct the _____insurance co. to pay by check made out to and mailed directly to: After Hours Medical Group 9200 Colima Rd Ste # 101., Whittier, CA 90605, for the professional or medical expense benefits allowable and otherwise payable to me under current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance and/or Co-pay of said professional service charges over and above the insurance payment.

Date: _____ Name: _____ Signature: _____