

.....  
SOUTH COAST MEDICAL CLINIC  
408 WEST 8TH STREET, NATIONAL CITY CA 91950  
.....

IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION  
FILLED OUT COMPLETELY. PLEASE PRINT CAREFULLY  
.....

PATIENT NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: MALE/ FEMALE

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

TELEPHONE NUMBER (HOME) \_\_\_\_\_ (WORK): \_\_\_\_\_ EXT \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ SPOUSE NAME: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

DRIVER'S LICENSE NUMBER: \_\_\_\_\_  
.....

RESPONSIBLE PARTY NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

TELEPHONE NUMBER: (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_  
.....

DO YOU HAVE MEDICAL INSURANCE? \_\_\_\_\_ NAME: \_\_\_\_\_

HAVE YOU MET YOUR DEDUCTIBLE THIS YEAR? \_\_\_\_\_ YES \_\_\_\_\_ NO

HOW WILL YOU PAY FOR YOUR VISIT TODAY? \_\_\_\_\_ CASH \_\_\_\_\_ MASTERCARD

\* CHECKS FROM ESTABLISHED PATIENT ONLY \_\_\_\_\_ VISA \_\_\_\_\_ CHECK\*

PRIMARY INSURANCE NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

PRIMARY INSURANCE ADDRESS: \_\_\_\_\_

MEMBERSHIP NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

SECONDARY INSURANCE ADDRESS: \_\_\_\_\_

MEMBERSHIP NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_  
.....

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE WHETHER MY INSURANCE MY INSURANCE COMPANY PAYS OR NOT, FOR ALL CHARGES INCURRED BY ME. I FURTHER AGREE THAT IN THE EVENT OF NONPAYMENT, I WILL BEAR THE COST OF COLLECTION AND/ OR COURT COST AND RESPONSIBLE LEGAL FEES SHOULD SUCH ACTION BE REQUIRED. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL. I AUTHORIZED MY INSURANCE TO MAKE PAYMENT DIRECTLY TO SCMC FOR CHARGES I HAVE INCURRED THERE.

SIGNATURE: \_\_\_\_\_ PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_