|  |  |
| --- | --- |
| **Patient Name (please print):** | **Responsible Party (if other than patient):** |
| **Street Address:** | **Street Address:** |
| **City, State, Zip:** | **City, State, Zip:** |
| **Date of Birth:**  | **Date of Birth:**  |
| **Social Security Number:**  | **Social Security Number:**  |
| **Sex(please circle): M or F** | **Sex(please circle): M or F** |
| **Marital Status:** | **Marital Status:** |
| **Home Phone:** | **Home Phone:** |
| **Work Phone:**  | **Work Phone:**  |
| **Mobile Phone:** | **Mobile Phone:** |
| **Email:**  | **Email:** |
|  |
| **Primary Insurance:** | **Primary Insurance Policy #:** |
| **Primary Insurance Phone Number:**  | **Primary Insurance Group #:** |
| **Primary Insurance Address:** |
|  |
| **Secondary Insurance:** | **Secondary Insurance Policy #:**  |
| **Secondary Insurance Phone Number:**  | **Secondary Insurance Group #:** |
| **Secondary Insurance Address:** |
|  |
| **Emergency Contact Name/Relationship:** |
| **Emergency Contact Phone:** | **Your Preferred Pharmacy (name):**  |
| **Emergency Contact E-mail:** | **Your Preferred Pharmacy (number):** |
|  |
| **Patient’s Employer Name:** | **Employer of Policyholder:** |
| **Phone Number:** | **Phone Number:** |
| **Patient’s Occupation:** |
|  |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ethnicity (circle one):** | **Hispanic or Latino** | **Not Hispanic or Latino** | **Declined** | **Unknown** |

 |
|  |
| **Preferred Communication (circle one):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Email** | **Patient Portal** | **Phone** | **Mail** | **Fax** |

**Race (circle one):**

|  |  |
| --- | --- |
| **American Indian/Alaska Native** | **Caucasian** |
| **Asian** | **Latino** |
| **Black/African American** | **Decline** |
| **Native Hawaiian/Pacific Islander** | **Unknown** |
| **Other** |

 | **Primary Language Used (circle one):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Arabic** | **French** | **Italian** | **Portugese** |
| **Chinese** | **German** | **Japanese** | **Russian** |
| **English** | **Greek** | **Korean** | **Spanish** |
| **Filipino** | **Hindi** | **Polish** | **Vietnamese** |
| **Other:** |

Primary Care Physician: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
|  |
| **Initial****\_\_\_\_ I authorize release of any medical information necessary to process my claims to all my insurance companies.****­­­\_\_\_\_ I authorize direct payment of medical benefits to Rheumatology Associates of Southern California.****\_\_\_\_ I permit a copy of this authorization to be used in place of the original.****\_\_\_\_ I have read and understand the financial policy.** |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**