|  |  |  |
| --- | --- | --- |
| **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**