PACIFIC INFUSION CENTER

Friendly • Experienced • Caring

¤ 5230 Pacific Concourse Dr., STE 100 Los Angeles, CA 90045 ¤ 1260 15th St., STE 1400 Santa Monica, CA 90404

Patient Registration – Confidential

Patient Name: ______ Date of Birth: ______ Today's Date: ______
Street Address: ______ City, State: ______ Zip: ______
Phone #: ______ SS#: ______
Email Address: ______
Referring Physician: ______ Address/Phone: ______
Employer: ______ Occupation: ______
Employer Address: ______ Work/Cell Phone #: ______
Marital Status: S M W D Sep
Please circle one
Spouse's Name: ______ Date of Birth: ______
Employer/Occupation: ______ Phone #: ______
Emergency Contact Name: ______ Relation: ______
Phone #: ______
Address: ______

Billing Information/Responsible Party – Payment required at time of service unless prior arrangements made

Billing Name (if other than patient): ______ Relation: ______
Billing Address: ______

Insurance Information

Primary Insurance Company: ______ Phone #: ______
Address: ______
Name of Insured: ______ Relation to Patient: ______
Additional Insurance Company: ______ Phone #: ______
Address: ______
Name of Insured: ______ Relation to Patient: ______
Medicare #: ______ Medicaid #: ______
Is your condition employment related?: Y N If yes, date of injury: ______
Is your condition accident related?: Y N If yes, date of injury: ______
Name of Attorney (if applicable): ______
Address: ______ City: ______ Phone #: ______

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Pacific Infusion Center for services rendered by him in person and under his supervision. I understand that I am financially responsible for any balance not covered by my insurance plan.

Initial/Date: ______/______

Authorization to Release Information

I hereby authorize Pacific Infusion Center to release any medical or incidental information that may be necessary for either medical care or in processing information for medical benefits.

Initial/Date: ______/______

Medicare/Medicaid

I certify that the information given me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Initial/Date: ______/______

A photocopy of these assignments shall be valid as the original.

Patient Name (please print):______________________________ Date:______________

Signature of Insured:______________________________ Date:______________