**PATIENT INFORMATION** **PLEASE PRINT CLEARLY**

**PATIENT NAME**

**First: ____________________________MI:________ Last: ____________________________**
**Sex:____________SSN: ______________________________DOB: ________________________**
**E-mail address____________________________________________________________________**
**Address: ________________________________ City, State, Zip:_________________________**
**Home Phone# _________________Work Phone# ____________________Cell#______________**

**If patient is a minor, please list parents names:_________________________________________**
**Parent's SS# ______________________Relationship to patient___________________________**

**Family Doctor: _________________________________Phone#___________________________**
**Date Last Seen:___________________**

**PLEASE TELL US HOW YOU KNOW ABOUT OUR OFFICE OR HOW REFERRED:**

**Family Doctor___ Insurance Directory___ Yellow Pages___ White Pages ___ Internet______**
**Family: (name/relationship) _______________________Friend: (name)___________________**
**If other, please list: _______________________________________________________________**
**Preferred Language ___English Other-please list______________________**
**Race:**
**Check One: American Indian or Alaska Native______ Black or African American_____**
**Native Hawaiian Or other Pacific Islander____ White_____**
**Refuse to report ____**
**Emergency Contact: _____________________________**
**Relationship to patient: ________________________________________**
**Phone#___________________________**

**INSURANCE INFORMATION**

**Primary Insurance Company: _____________________________________________________**
**Subscriber's Name: ________________________SSN:___________________DOB:__________**
**Relationship to patient: __________________________________________________________**
**Secondary Insurance Company: ____________________________________________________**
**Subscriber's Name: ________________________SSN:___________________DOB:___________**

**Marital Status: Married __ Single __ Widowed __ Separated __**
**Employment Status: Full Time __ Part Time __ Self- employed __ Unemployed __ Retired __ Military __**

**EMPLOYMENT INFORMATION**

**Patient's Employer: ________________________________________________________________**
**Address: ___________________________City: ______________Phone#_____________________**
**Occupation: ___________________________**

**Signature on file:**

**The undersigned hereby authorizes the release of any medical information necessary to process insurance claims as may be payable to the undersigned under any contract of insurance with respect to services rendered by Dr. George Rutan. If assignment is accepted, I authorize direct payment to Dr. George Rutan. The undersigned hereby agrees to be financially responsible for any charges not covered by the insurance company.**

______________________________________________________________________________

**Signature** **Date**