

NAME: LAST		FIRST	MIDDLE INITIAL	AGE
ADDRESS:		CITY	ZIP	
HOME PHONE () _____		DATE OF BIRTH _____		
WORK PHONE () _____		SOCIAL SECURITY # _____		
MARITAL STATUS		GENDER		
SINGLE MARRIED WIDOWED		MALE FEMALE		
EMPLOYER		OCCUPATION		
SPOUSE OR RESPONSIBLE PERSON:		DATE OF BIRTH	HOME PHONE	
NAME			()	
EMPLOYER		OCCUPATION	WORK PHONE	
			()	
NAME OF EMERGENCY CONTACT:		PHONES		
		WORK ()		
		HOME ()		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

COPAY \$ _____

INSURANCE INFORMATION

PPO (OTHER)
 BLUE CROSS PPO
 BLUE SHIELD PPO
 MEDICARE
 MEDICAL

BLUE CROSS MEDICAL
 HMO - BFMC
 HMO - GEMCARE
 HMO - DELANO REGIONAL
 HMO - CENTENNIAL
 HMO - KERN FAMILY

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN TO MARTIN BERRY, M.D., Inc., ALL PAYMENTS, WHICH I AM ENTITLED TO OR MEDICAL EXPENSES, INCLUDING MAJOR MEDICAL AND SUPPLEMENTAL BENEFITS RELATIVE TO THE SERVICES RENDERED FOR THE ABOVE. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO MARTIN BERRY, M.D., Inc. FOR THE CHARGES NOT COVERED BY THIS ASSIGNMENT. A PHOTOSTAT OF THIS ASSIGNMENT IS AS VALID AS THE ORIGINAL

DATE _____ SIGNATURE _____