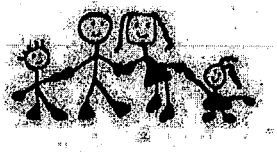
For Practice Use Only: Apt. Date: Time: Account#: Doctor:



DOS PALOS APEX HEALTH CENTER

1549 Golden Gate St.
Dos Palos, CA 93620
Phone (209)392-0022 Fax (209)392-0011

Patient Name: (First, Middle Initial, Last) _____

Social Security Number: _____ Birth Date (MM/DD/YYYY): _____ Gender: _____

Address: _____

City State Zip

Daytime Phone: _____ Home Phone: _____ Cell Phone: _____

E-mail: _____ **Marital Status:** Married Single Divorced Widowed

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City State Zip

Race: American Indian/Alaska Native Asian Black White Native Hawaiian/Pacific Islander Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Preferred Language Spoken** _____

Minor Patient: Patient resides with? Name: _____ Relationship: _____

Responsible Party (For example "self" or give details of parent, guardian, or other person responsible for consent and payment):

Name: _____ Relationship to Patient: _____

Social Security Number _____ Birth Date (MM/DD/YYYY): _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City State Zip

Emergency Contact: (A person we may contact if unable to reach patient and/or responsible party):

Name: _____ Relationship to Patient: _____

Phone: _____ Alt Phone: _____

Does the patient have insurance? Yes / No / (Please present your cards so that copies may be made.)

Primary Insurance: _____ Policy Holder: _____

ID#: _____ Group#: _____

Claims Address: _____

Policy Holder's SSN: _____ Policy Holder's Birth Date: _____

Secondary Insurance: _____ Policy Holder: _____

ID#: _____ Group#: _____

Claims Address: _____

Policy Holder's SSN: _____ Policy Holder's Birth Date: _____

Confidentiality Information

Confidentiality laws state that no medical information regarding diagnosis or treatment of a patient can be released to any other person(s) without the written consent of the patient (or guardian, if applicable).

Please provide us with the names and phone numbers of any people with whom you wish for us to be able to share your medical information, such as spouse, family members, or friends:

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Consent to treat a minor: By law, minors must be accompanied by a parent or guardian. If a parent or guardian is unable to accompany your minor, we must have a signed release on file. Please list below the name(s) of the person(s) you wish to give permission to accompany your minor to their visits as well as to consent to any necessary examination, anesthetic, medical diagnosis, minor surgery, or treatment to be rendered under the general supervision or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of California. (Note: This expires in one year. After a year, you will be asked to fill out a separate minor consent form.)

Name: _____ Relationship: _____ Signature: _____

Name: _____ Relationship: _____ Signature: _____

Name: _____ Relationship: _____ Signature: _____

Financial Responsibility Statement/Release of Information

I hereby authorize treatment and authorize Dos Palos Apex Health Center to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf.

_____ _____

Signature of Patient or Parent/Guardian Date