SAN BERNARDINO MEDICAL GROUP, INC.

1700 NORTH WATERMAN AVENUE
SAN BERNARDINO, CALIFORNIA 92404
(909) 883-8611

PATIENT INFORMATION SHEET

PATIENT INFORMATION:

DATE	ACCOUNT NO.

PATIENT NAME	SEX	AGE	DATE OF BIRTH	MARITAL STATUS	SOCIAL SECURITY NO.

ADDRESS	PHONE

CITY	STATE	ZIP CODE

LICENSE NO. STATE	REFERRED BY	OCCUPATION	EMPLOYER

EMPLOYER'S ADDRESS	PHONE

SPOUSE'S NAME	SPOUSE'S OCCUPATION	SPOUSE'S EMPLOYER

SPOUSE'S EMPLOYER ADDRESS	PHONE

RELATIVE OR EMERGENCY CONTACT (NAME & ADDRESS)	PHONE

RESPONSIBLE PARTY:

NAME	RELATION TO GUARANTOR	SOC. SEC. NO.	DR. LICENSE STATE	EMERGENCY OR WORK NO..

ADDRESS	HOME PHONE

EMPLOYER NAME & ADDRESS	PHONE

INSURANCE INFORMATION:

PRIMARY	INSURANCE COMPANY	PRIMARY POLICY NO.	GROUP NO.	RELATION TO GUARANTOR

INSURANCE COMPANY'S ADDRESS	PHONE

SUBSCRIBER	EMPLOYER'S NAME	PHONE

SECONDARY	INSURANCE COMPANY	PRIMARY POLICY NO.	GROUP NO.	RELATION TO GUARANTOR

INSURANCE COMPANY'S ADDRESS	PHONE

SUBSCRIBER	EMPLOYER'S NAME	PHONE

CONSENT FOR RELEASE OF MEDICAL RECORDS AND DIRECT PAYMENT

AUTHORIZATION

I hereby authorize and direct my insurance carrier to pay directly to the provider any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan.

X_____
AUTHORIZED SIGNATURE

AUTHORIZATION

I hereby authorize the provider to release to my insurance company any medical information necessary to process this claim.

X_____
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