Today's
Date ____ /____ /____

Rancho Santa Fe Medical Group, Inc.
Mobile Doctor Medical Clinic

Patient Information Form

Mobile Doctor Medical Clinic
In-home medical services

Name ______________________________ D.O.B.____ /____ /____ Gender: Male Female

Patient Address ______________________________ Nursing Agency ______________________________

City ____________________ ST______ Zip __________ Nursing Agency Phone# ______________________________

Podiatry Yes No

Place of Service/Facility ______________________________

Physician preference ______________________________

Home Phone ______________________________

Emergency Contact ______________________________

Cell Phone ______________ Work ______________

Address ______________________________

Referred by ______________________________

Phone ______________ Relationship ______________

Phone ______________________________

Patient Information

SS# ___ ___ ___-___ ___-___ ___ ___ ___ MCR# ___ ___ ___-___ ___-___ ___ ___ ___

MCAL# ______________________________ Primary Ins. ______________________________

Conservator ______________________________ Policy# ______________ Group#______

Address ______________________________ Telephone# ______________________________

City ____________________ ST______ Zip __________ 2ndary Ins. ______________________________

Phone ______________________________ Policy# ______________ Group# ______

Conformation #____________________ Conf. Date ____________________ Verified by ______________

Cash Patient-YES Credit Card #____________________ Exp. Date__________ Billing Zip Code______

3 digit code on back of credit card __________

Patient Responsibility

Patient Consent: I hereby consent to and authorize the performance of medical treatment and any other surgical procedures which may be considered necessary or advisable by the attending physician. I also consent to and authorize any procedure or treatment to be documented with digital photography.

Financial Agreement: I hereby agree that I am financially responsible to the physician for all charges or any amount that is not paid or covered by insurance. It is the patients' responsibitlity to see that the bill is paid in full. We must emphasize that, as your medical care provider, our relationship is with you and not your insurance company. We will try to make sure that your insurance claim will be filed on the same day or the next day following your visit. The filing of a medical insurance claim is an expensive process that we extend to you at no charge as a courtesy. However, we do ask that you pay all co-pays, deductables, and non-covered charges the day of your service. All charges are your responsibility and insurance company's.

Assignment of insurance benefits/release of information: The physician may disclose all or any part of the patients record according to Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I authorize my insurance company to pay benefits directly to the physician for services rendered.

Signature ______________________________