

Comprehensive Breast Care of San Diego

3075 Health Center Drive,
Suite 102
San Diego, CA 92123
Tel.:858.637.7888 FAX:858.637.7883

PATIENT REGISTRATION

DATE _____
FIRST NAME _____ MIDDLE _____ HOME ADDRESS _____
LAST NAME _____
SEX ___ DATE OF BIRTH ___/___/___ CITY _____ STATE _____ ZIP _____
PRIMARY LANGUAGE _____ EMAIL _____
MARITAL STATUS ___ MARRIED ___ SINGLE HOME PHONE (____) _____
___ DIVORCED ___ WIDOWED CELL PHONE (____) _____
WORK STATUS ___ EMPLOYED ___ RETIRED REFERRING _____ PHYSICIAN _____
___ OTHER _____ HOW DID YOU HEAR OF US? _____
EMPLOYER _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

___ COMMERCIAL ___ MEDICAL ___ MEDICARE ___ OTHER _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP# _____ PHONE (____) _____

SECONDARY INSURANCE

___ COMMERCIAL ___ MEDICAL ___ MEDICARE ___ OTHER _____
INSURANCE COMPANY _____
INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____
POLICY # _____ GROUP# _____ PHONE (____) _____

EMERGENCY CONTACT

FIRST NAME _____ MI _____ HOME PHONE (____) _____
LAST NAME _____ CELL PHONE (____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

RELATIONSHIP _____ SEX _____ DATE OF BIRTH ___/___/___
FIRST NAME _____ MIDDLE _____ LAST NAME _____ DAYTIME PHONE (____) _____
NAME _____ EMPLOYER _____
ADDRESS _____ ADDRESS _____
CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE DATE

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BRIEF MEDICAL INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____

DATE OF BIRTH ____/____/____

Primary Physician: _____

Dominant Hand: Right Left

Do you have a pacemaker, stent, or any metal or clips implanted? Yes No

Do you take heart or blood pressure medication? Yes No

Do you take blood thinners? Yes No

Are you diabetic? Yes No

If yes, please list any medication: _____

Please list any known allergies: _____

Please list any recent surgeries, including type of surgery and approximate date:

Please list any medications you presently take:

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AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL RECORDS

I hereby authorize

(Name and Address of Physician, Hospital or Health Care Provider)

to furnish to

(Name of Physician)

any and all medical records and information pertaining to my medical history and/or treatment.

CONFIDENTIALITY NOTICE: THE INFORMATION CONTAINED IN THIS RELEASE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW.

Printed Name of Patient

Signature of Patient

Date

Maiden/Previous Name

If signed by other than patient, indicate relationship and reason:

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FINANCIAL POLICY FOR MEDICAL ONCOLOGY ASSOCIATES OF SAN DIEGO

Dear Patient,

Our office will be happy to bill your primary and secondary insurance carrier if the proper information has been provided. We will need to copy your insurance card at the time of your visit.

If you wish to bill your own secondary insurance, please use a copy of your itemized monthly statements. If you need assistance with the secondary billing procedure or if you have any questions regarding your account, please contact our Business Office.

Our office will bill your HMO insurance for services rendered. In addition, most HMO insurance companies require the patient to pay a co-payment at the time of service. Please inform our office if your insurance provider requires a "co-pay".

Patients are responsible for the balance due in full if their insurance company fails to pay. If you feel that your insurance company has not responded to your claim, please contact your insurance company. It is your responsibility to assist with any problems that result from an unpaid claim. Also, be advised that if we are not notified of changes (i.e., group number, insurance address, HMO changes) or new insurance coverage, you will be responsible for payment in full.

Please contact our Business Office if you have any questions regarding our financial policy.

Printed Name of Patient

Signature of Patient

Date

Maiden/Previous Name

If signed by other than patient, indicate relationship and reason:
