GARBER FORBESS RHEUMATOLOGY – NEW PATIENT INFORMATION

DATE

THIS SECTION REFERS TO PATIENT ONLY

NAME	SEX ☐ MALE ☐ FEMALE	AGE	BIRTH DATE / /	MARITAL STATUS ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MARRIED
ADDRESS	SOC SEC NO			
CITY STATE ZIP	EMPLOYER NAME			
HOME PHONE ( ) · WORK PHONE ( ) · CELL PHONE ( )	ADDRESS			
DRIVERS LIC # · OCCUPATION · EMAIL ADDRESS	CITY STATE ZIP			
NAME OF SPOUSE	SPOUSE'S OCCUPATION			BIRTHDATE / /

COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN PATIENT

NAME	RELATION TO PATIENT	SOC SEC NO	OCCUPATION
ADDRESS		EMPLOYER	
CITY STATE ZIP		ADDRESS	
HOME PHONE ( )	WORK PHONE ( )	CITY STATE ZIP	

INSURANCE INFORMATION

PLEASE CHECK ALL THAT APPLY ☐ NO COVERAGE ☐ MEDICARE # ____________ ☐ PRIVATE ☐ WORKER'S COMP

NAME OF INSURANCE COMPANY		NAME OF INSURANCE CO	
ADDRESS		ADDRESS	
NAME OF INSURED		NAME OF INSURED	
GROUP NO/COMPANY NAME	PHONE ( )	GROUP NO/COMPANY NAME	PHONE ( )
POLICY/CERT NO	EFFECTIVE DATE / /	POLICY/CERT NO	EFFECTIVE DATE / /
PATIENT IS ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER SPECIFY ________		PATIENT IS ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER SPECIFY ________	
DOES INSURANCE COVER ☐ OFFICE CARE ? ☐ HOSPITAL ?		DOES INSURANCE COVER ☐ OFFICE CARE ? ☐ HOSPITAL ?	

OTHER INFORMATION

REFERRED BY	PHONE ( )	FAMILY PHYSICIAN	PHONE ( )
DRUG ALLERGIES		PREFERRED PHARMACY	PHARMACY PHONE ( )
REASON FOR CONSULTATION		PHARMACY ADDRESS	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE GARBER FORBESS RHEUMATOLOGY TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO INSURANCE CARRIERS AND I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO GARBER FORBESS RHEUMATOLOGY, 8631 WEST THIRD STREET, SUITE 700E, LOS ANGELES, CALIFORNIA 90048. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED VALID AS AN ORIGINAL. I HAVE READ AND AGREE TO ABIDE BY GARBER FORBESS RHEUMATOLOGY'S SUBSPECIALTY PRACTICE POLICY, ITS FEES AND PAYMENTS POLICY AND ITS MEDICARE AND PRIVATE INSURANCE POLICY.

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(DATE) *(PRINT PATIENT'S NAME)* *(PATIENT'S SIGNATURE)*