Soledad Medical Clinic

Patient Information

Name _____
(First Name) (M / I) (Last Name)

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Birthday _____

Soc. Sec. Number _____

Sex: ☐ Male ☐ Female

Ethnicity _____ Language _____

Pharmacy _____

Employer _____

Emergency Contact _____

Emergency Contact Phone _____

Financially Responsible Party

Name _____
(First Name) (M / I) (Last Name)

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Ph _____ Work Ph _____

Birthday _____

Soc. Sec. Number _____

Relationship To Patient _____

Employer _____

Insurance

Do you have insurance coverage? □ Yes □ No

If yes, please present your insurance information to the Receptionist.

I consent to the procedures that may be performed during my examination and treatment at the Clinic. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment at this clinic.

I assign and authorize direct payment to the Clinic of all insurance and health plan benefits payable for these outpatient services. I agree that the insurer or plan's payment to the Clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law.

By signing this form I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for the Soledad Medical Clinic.

By signing this form I acknowledge that I have received a copy of the Notice of Patient's Rights for the Soledad Medical Clinic.

_____ _____

(Patient or Guardian Signature) (Date)