NATOMAS
FAMILY PRACTICE INC.

2410 Del Paso Rd. Sacramento, CA 95834
Office: (916)928-0856 Fax:(916)928-1584

PATIENT DEMOGRAPHICS

Date _____

PATIENT FULL NAME: _____

Date of Birth: _____ **Social Security Number:** _____ - _____ - _____

EMAIL: _____

PATIENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Patient Mobile: _____ **Home Number:** _____

***** IF PATIENT IS UNDER 18 YEARS OF AGE *****

Guarantor/Responsible Party Name: _____

Guarantor/Responsible Party SSN: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ DOB: _____ SSN: _____ - _____ - _____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER

Ins ID/Policy Number: _____ Group: _____ Effective Date: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ DOB: _____ SSN: _____ - _____ - _____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER

Ins ID/Policy Number: _____ Group: _____ Effective Date: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone:

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FINANCIAL AGREEMENT

I authorize the release of any medical information necessary to process the claim and request that payment of any benefits be made to the undersigned physician or supplier for services described below. I understand I am financially responsible for non-covered benefits and all deductibles not covered by the authorization. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney fees and collection expenses. *I UNDERSTAND THAT NATOMAS FAMILY PRACTICE DOES NOT HAVE A MEDI-CAL (GOVERNMENT SPONSERED INSURANCE) CONTRACT. THEY WILL NOT BE BILLED, THEREFORE WE WILL NOT BE ABLE TO PROVIDE ANY SERVICES TO PATIENTS WITH MEDI-CAL.* I certify that everything above is filled out to the best of my knowledge.

It is your responsibility to notify us of any changes to your insurance, home or mailing address and phone number(s). Please return this signed form to the receptionist.

Thank you for your Cooperation.

SIGNATURE: _____ **DATE:** _____

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HIPAA FORM

(People we can speak to other than yourself)

PATIENT NAME:_____ **Date of Birth:**_____

We may release Information to:

☐ Name/ Relationship to Patient:

☐ Do not release my information to anyone

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT FOR ONE YEAR OR UNTIL TERMINATED BY ME IN WRITING.

Please select one if unable to reach you:

☐ May leave a Detailed Message including Health Information

☐ Please leave message asking me to return the Call

SIGNATURE: _____ **DATE:** _____