

G.M.Sally Mellgren, M.D., Inc.

3621 Vista Way

Oceanside, CA 92056

760-757-1144

Patient Information Sheet

Please Print

Name of Patient: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: F M

Home Phone: _____ Work Phone: _____ Other: _____

Patient Address: _____ City, State, Zip: _____

Patient's Employer: _____

Spouse/Insured Name: _____ Work Number: _____

SSN: _____ Spouse/Insured Date of Birth: _____

EMERGENCY CONTACT AND/OR RESPONSIBLE PARTY

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE

Primary Coverage: _____ Policy# _____

Secondary Coverage: _____ Policy# _____

Referred to this office by: _____

Primary Physician: _____

PLEASE SIGN THE FOLLOWING

I understand that I am financially responsible for all charges whether or not paid for by insurance

Signature of patient

Date

Please remember that insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

..... **OVER**

Medicare Patients Please Sign the Extended Authorization Below:

Name of beneficiary-Name on Medicare Card

Medicare Number

I request that payment of authorized Medicare benefits be made on my behalf to G.M.Sally Mellgren, M.D., Inc., for any services rendered to me by Dr. Mellgren or her associates. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of patient: _____

Date: _____

PRIVATE INSURANCE

I authorize and direct my Insurance Company _____ to pay all medical and surgical bills incurred on behalf of the patient _____ to G.M.Sally Mellgren, M.D., Inc. I authorize any holder of medical information to release to my insurance company information needed to determine these benefits or the benefits payable for related services.

Signature of Patient

Date

RECORD RELEASE AUTHORITY

I, _____ hereby grant permission to Dr. Mellgren and/or staff to release any health information of my diagnosis, treat, prognosis and recommendations, as well as any other data pertinent to my treatment to my insurance company or physician.

I have received or been offered a copy of the privacy policy for G.M.Sally Mellgren, M.D., Inc.

I hereby authorize Dr. Mellgren and her staff/associates to leave messages on my answering machine.

I hereby authorize Dr. Mellgren and her staff/ associates to discuss my care with the following people:

Name

Relationship

Signature of Patient

Date