



Moorpark Family Medicine

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Patient Information

Last Name _____ First _____ MI ____ Date of Birth _____ Age ____ Sex M / F
Street Address _____ City _____ State ____ Zip Code _____ Social Security # _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
E-Mail Address _____ Marital Status: Single / Married / Divorced / Widowed
Where did you hear about us? _____

Employer Information

Patient's Occupation _____ Patient's Employer _____ Phone (____) _____
Employer's Address _____ City _____ State ____ Zip Code _____

Emergency Information – IN CASE OF EMERGENCY

Name _____ Relationship to patient _____ Phone (____) _____
Address _____ City _____ State ____ Zip Code _____

Spouse/Responsible Party Information

Responsible Party _____ Date of Birth _____ Age ____ Social Security # _____
Address _____ Phone (____) _____ Relationship to Patient _____

Primary Insurance Name

Subscriber's Name _____ DOB _____
ID # _____ Group # _____

Secondary Insurance Name

Subscriber's Name _____ DOB _____
ID # _____ Group # _____

Assignment of Benefits

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowance for certain procedures, they sometimes refer to as "reasonable and customary fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only 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. **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT.** In the event the account is turned over for collection, the collection fee and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Moorpark Family Medicine, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

Signature _____ Date _____

Medication History

Our electronic system obtains your medication history from the national pharmacy network. This information is not downloaded automatically and requires your consent. Your signature below is your consent for us to obtain this information in order to better evaluate your medical needs. If you decline, please write decline on the signature line.

Signature _____ Date _____