Endoscopy Center at Skypark

23441 Madison St. / Suite 230 / Torrance, Ca 90505 / Tel: (310) 375-6461 / Fax (310) 375-7201

PATIENT NAME: _____/_____/_____/F__M___
LAST FIRST MI

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE: ( ) _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SOCIAL SECURITY #:** _____

EMPLOYER: _____ **PHONE#** _____

ADDRESS: _____ **CITY**_____ **STATE**___ **ZIP**_____

SPOUSES NAME _____**D O B** _____

WHO WILL DRIVE YOU HOME TODAY? NAME: _____**PH#**_____

FAMILY PHYSICIAN (PCP) NAME: _____ **PH#**_____

INSURANCE INFORMATION: (PLEASE COMPLETE IN FULL)

PRIMARY INS: **HMO**_____ **PPO**_____ **MEDICARE**_____

INS CO NAME: _____

ID # _____

SELF___ **SPOUSE**_____**OTHER**___

SS # _____ **DOB** _____

SECONDARY INS:

INS CO NAME: _____

ID # _____

SELF_____ **SPOUSE**_____ **OTHER**_____

SS# _____ **DOB:**_____

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY:

I HEREBY ASSIGN TO THE PHYSICIAN ALL MEDICAL BENEFITS UNDER MY INSURANCE POLICY, WHICH IAM ENTITLED FOR MEDICAL AND OR SURGICAL EXPENSES RELATED TO SERVICES PROVIDED. I HEREBYAUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATIONOR PROCEDURE NECESSARY TO PROCESS INSURANCE CLAIMS. I UNDERSTAND A PHOTOCOPY TO BECONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AFTER 45 DAYS FOR THE CHARGES NOT PAID AND / OR COVERED BY MY INSURANCE.

Signature:_____ Date: _____