Los Alamitos
CARDIOVASCULAR
3771 KATELLA AVENUE • SUITE 300
LOS ALAMITOS, CA 90720
(562) 430-7533 • (714) 827-9850

Alan Gold, M.D. ☐
Stuart Fischer, M.D. ☐
Timothy O'Neill, M.D. ☐
Steven Forman, M.D. ☐
Bret Witter, M.D. ☐
Ramandeep K. Brar, M.D. ☐

# PATIENT INFORMATION SHEET

## PATIENT INFORMATION:

Last Name: ______________________ Home Phone #: ______________________

First Name: ______________ M.I. ______ Work Phone #: ______________________

Street Address: ______________________ Date of Birth: ______________________

City: ______________ State: ______ Social Security #: ______________________

Zip Code: ______________ Sex (M/F): ______ Marital Status: ______________________

Driver License #: ______________________ Occupation: ______________________

Employer: ______________________ Who may we thank for referring you to this office?: ______

Address: ______________________ ______________________

Are you allergic to any medications? ☐ NO ☐ YES

If yes, which medications? ____________________________________________

Contact in case of EMERGENCY: ______________________ Phone #: ______________________

Relationship: ______________________

## GUARANTOR / PARENT / INSURED INFORMATION (SEND BILL TO):

Name: ______________________ Social Security #: ______________________

Employer: ______________________ Phone #: ______________________

Address: ______________________ Relationship to Patient: ______________________

### **PRIMARY** INSURANCE CARRIED BY PATIENT

Insurance Co. Name: ______________________

Billing Address: ______________________
______________________

Group or Policy #: ______________________

Cert. or Member #: ______________________

Local Union #: ______________________

Name of Insured: ______________________

Insured's DOB: ______________________

### **SECONDARY** INSURANCE INFORMATION

Insurance Co. Name: ______________________

Billing Address: ______________________
______________________

Group or Policy #: ______________________

Cert. or Member #: ______________________

Local Union #: ______________________

Name of Insured: ______________________

Insured's DOB: ______________________

I hereby assign all medical / or surgical benefits to include major medical benefits to which I am entitled, including Medicare and all other insurance to Los Alamitos Internal Medical Group, Inc. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for all the charges incurred, including but not limited to copayments and annual deductible. I am also responsible for the charges denied by either Medicare and or all other insurance. I hereby consent to and authorize all treatment and medical services by the physician(s) and staff of this office as they deem necessary. I authorize the release of any information regarding my history, treatment, findings, and other clinical studies and diagnosis that this office deems necessary.

PATIENT SIGNATURE ______________________ INSURED SIGNATURE ______________________

PATIENT OR GUARDIAN SIGNATURE OF MINOR ______________________

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. DATE ______________________