

George H. Sanders, M.D., APC

TODAY'S DATE: _____

PATIENT INFORMATION:

___ Single ___ Married ___ Other

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street

EMAIL ADDRESS: _____
City State Zip Code

HOME PHONE: (____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___ CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

RESPONSIBLE PARTY INFORMATION: RELATIONSHIP TO PATIENT: ___ SELF ___ SPOUSE ___ PARENT ___ OTHER

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street City State Zip Code

HOME PHONE: (____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___ CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP/POLICY NUMBER: _____

SECONDARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP/POLICY NUMBER: _____

DO YOU HAVE ANOTHER HEALTH BENEFIT PLAN? ___ YES ___ NO
IS YOUR CONDITION RELATED TO: ___ EMPLOYMENT ___ AUTO ACCIDENT ___ OTHER ACCIDENT

WHO REFERRED YOU TO OUR OFFICE? _____

NAME OF YOUR PERSONAL PHYSICIAN: _____
Name Phone number or city where practice is located

IN CASE OF EMERGENCY, NOTIFY: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

- I understand that Dr. Sanders and his staff comply with all HIPAA guidelines. At my request, any staff member will provide me a copy of those guidelines.
- **I authorize staff to leave messages on my cell phone or any other number that I designate.**
- I, the patient or responsible parties, authorize release of medical information for the purpose of processing medical claims.
- I also authorize my insurance company to pay benefits directly to George H. Sanders, M.D., APC.
- I authorize Dr. Sanders to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that Encino Surgicenter is co-owned by George H. Sanders, MD and Stephen D. Bresnick, MD.
- I understand that any cosmetic procedure I have with Dr. Sanders requires a \$1,000 non-refundable scheduling deposit.
- I hereby give permission to George H Sanders, MD and his staff to take photographs of myself with the understanding that such photographs are for confidential clinical records, and that all photographs remain the property of the doctor.

SIGNATURE: _____ DATE: _____