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 authorize the use of automated appointment confirmations by text, voicemail and email on the information listed above. If you do not wish to receive automated messages please initial here _____

- 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 scheduling deposit which is refundable up to 3 weeks before my agreed upon surgery date.
- 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:** _____