PT Dermographic

THIS INFORMATION IS CONFIDENTIAL, WE WOULD APPRECIATE YOUR COOPERATION IN FILLING OUT THIS FORM AS COMPLETELY AS POSSIBLE.

I WILL BE SEEING: DR. CHU____ DR. LAMA ____ DR. THAKER ____

Patient Name: _____ Date of Birth: _____ Age: _____
Marital Status (S) (M) (D) (W): _____ Name of Spouse: _____
Home Address: _____ Home Phone #: _____
City: _____ Zip Code _____ Work Phone #: _____
Patient Social Security #: _____ Employer: _____
Parent/ Guarantor Name: _____
Employers Address: _____ Driver License #: _____
Parent Guarantor Social Security #: _____
Friend/ Relative Name & Phone #: _____
Friend/ Relative Name & Phone #: _____
Allergies: _____
Name of Referring Doctor: _____ Medical Insurance: _____ Yes or No: _____
Name of Insurance Carrier: _____
Address of Insurance Carrier: _____
Subscribers Name: _____ Group #: _____ Policy #: _____

I understand and agree that, (**regardless of my insurance status**), I am ultimately responsible for the balance on my account for any services rendered, **with the exception of HMO's & PPO's with the proper referrals.** I have completed completed the above questions and certify this information is tru and correct to the best of my knowledge. I WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE INFORMATION.

_____

Patient/ Parent/ Guarantor Signature Date

ASSIGNMENT OF BENEFITS: The insurance company is hereby authorized per the attached claim and fee statement to pay directly to the below named physician the medical/ surgical benefits otherwise paid to me or my spouse. Any such benefits payable as noted above are to be remitted by check payable to the below named physician. All benefits are authorized to be paid to:

SAN BERNARDINO UROLOGICAL ASSOCIATION MEDICAL GROUP

(Franklin M. Chu, M.D. & Daniel J. Lama, M.D., & Nimish Thaker, M.D.)

_____

Patient/ Parent/ Guarantor Signature Date

If your minor child need emergency medical treatment and comes in or is brought in by any person other than a parent, please sign if you consent to their being treated in your absence.

_____

Parent or Guardian Signature Date

Franklin M. Chu, M.D., F.A.C.S.
Daniel J. Lama, M.D.
Diplomats American Board of Urology

Phone (909) 882-2973 • Fax (909) 882-2681
489 E 21st Street • San Bernardino, CA 92404