**INFORMATION FOR THE RESPONSIBLE PARTY**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name: | | AKA:<br>Social Security#: | | | | | | |
| Address: | City: | Zip: | E-Mail: | | | | | |
| Phone: | | Sex: | ☐ Male<br>☐ Female | ☐ Married<br>☐ Divorced | ☐ Single<br>☐ Separated | | | |
| Profession: | Driver's License: | Date of Birth: | Age: | | | | | |
| Why did you choose us? (circle one) Group as a whole / Specific MD / Both | | How did you find us? | ☐ Insurance<br>☐ Newspaper | ☐ Friend<br>☐ Other_____ | ☐ Yellow Pages | | | |
| Employer: | Address<br>City | Work Phone | | | | | | |

**SPOUSE**

| | | |
|---|---|---|
| Name: | Profession: | Date of Birth:<br>Age: |
| Employer: | Address:<br>City: | Work Phone: |

**CHILDREN**

| | | |
|---|---|---|
| Name: | Date of Birth: | Age: |
| Name: | Date of Birth: | Age: |
| Name: | Date of Birth: | Age: |
| Name: | Date of Birth: | Age: |

**IN CASE OF EMERGENCY**

| | | |
|---|---|---|
| Person to contact: | Relationship: | Day Phone:<br>Home Phone: |

**INSURANCE INFORMATION**

| | | |
|---|---|---|
| Name of Insurance: | | ☐ Group ☐ Medicare Supplement |
| Name of Insured: | | ☐ Individual<br>Effective Date of Coverage: |
| Certificate/Subscriber# | Group or Policy # | Account # |

**SPOUSE'S INSURANCE INFORMATION**

| | | |
|---|---|---|
| Name of Insurance: | | ☐ Group ☐ Medicare Supplement |
| Name of Insured: | | ☐ Individual<br>Effective Date of Coverage: |
| Certificate/Subscriber# | Group or Policy # | Account # |

**RELEASE OF MEDICAL INFORMATION:**

I authorize the release of any medical information necessary for care or treatment as well as to process this insurance claim.

Signature of responsible party: Date:

**PAYMENT OF BENEFITS ASSIGNMENT:**

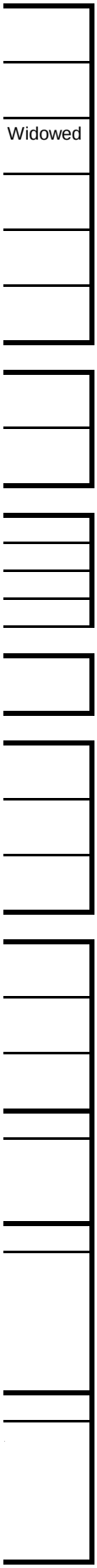
I hereby authorize my insurance benefits to be paid directly to ALTA CALIFORNIA MEDICAL GROUP, INC. I understand that I have full financial responsibility for all professional services rendered and will remit appropriate co-payments or charges at the time of service.

Signature of responsible party: Date:

**TREATMENT OF A MINOR:**

The undersigned parent or legal guardian of the above listed minor(s), do hereby authorize the physicians of ALTA CALIFORNIA MEDICAL GROUP, INC. and their staff to perform any x-ray examination, anesthetic, medical, or surgical care or treatment, which is deemed advisable, in the office or hospital

Signature of responsible party: Date:


Widowed