

Jorge A. Saldivar M.D., P.A.

Account #: _____

Patient's Name _____		Date of birth _____	Social Security Number _____
Spouse or Legal Guardian's Name _____		Relationship to patient _____	Marital Status: _____ (M) Married (S) Single
Address _____		Home telephone _____	Cellular telephone _____
City/ State/ Zip _____		Work telephone _____	Ext. _____
Employer's Name _____		Department _____	Occupation _____
Name of your Primary Care Physician (P.C.P.): _____		e-mail address (optional) _____	
Referred by: [] Dr. _____		[] Other _____	
Name and phone number of Dr. that referred you to us _____		How did you hear about us? _____	

Insurance Information

Please understand that all insurance requirements are the patient's/guarantor's responsibility, (including pre-certification). In most cases, we will file claims to insurance companies as a courtesy to our patients; however, the bill remains the patient's responsibility.

Primary Insurance Name _____		Secondary Insurance Name _____	
Phone Number _____		Phone Number _____	
Policy # _____	Group # _____	Policy # _____	Group # _____
Insured party's name _____	\$ _____ Co-pay	Insured Party's name _____	\$ _____ Co-pay

Insured Information (if other than patient):

Patient's relation: _____	Name _____	DOB _____	SSN _____
(S) self, (W) wife, (C) child	Employer _____	Work Telephone Number _____	Ext. _____

We need two emergency contacts:

1) Name: _____ Phone: _____ Relationship: _____
2) Name: _____ Phone: _____ Relationship: _____

Certification, request, authorization and consent for treatment

"By signing below, I certify that the information in this form is true and complete to the best of my knowledge. I understand this information will be used for regular medical office operations as stipulated in the notice of Privacy Practices for Jorge A. Saldivar, M.D. P.A.. A copy of this notice has been provided to me, I have read it, and understand my rights under this policy. I authorize this office to use this information as they deem necessary to contact me, to collect on charges, to submit claims to my insurance carrier(s), and to perform the regular business operations of this practice. I understand and authorize that my information might be transmitted electronically and via facsimile and I further authorize this office to release my information to physicians, medical facilities, and providers involved in my healthcare and understand that this authorization is valid for the next 24-month period. I certify that to my knowledge, I only have the healthcare insurance coverage provided by the insurance carrier(s) named above and authorize these carriers to issue direct payment to Jorge A. Saldivar, M.D., P.A. on my behalf for services rendered. I understand that if there are any changes in my information, including insurance coverage, I must notify this office immediately."

I also certify that with my signature below that I give Jorge A. Saldivar, M.D., P.A. my informed consent to instruct, guide and treat my healthcare needs. I also authorize Dr. Saldivar to perform the clinical test(s) that, per his discretion, feels are necessary, in an attempt to ensure the best possible outcome.

Patient's/ Legal guardian's Signature: _____ Date: _____

(Please allow us to obtain a copy of your insurance card and picture ID). Thank You !