

ARTURO QUINTANILLA, MD, FAAP
35-900 BOB HOPE DR. STE. 140
RANCHO MIRAGE, CA 92270
760-770-0000

PATIENT INFORMATION SHEET

DATE _____

NEW PATIENT _____ UPDATE _____

PATIENT'S NAME _____ D.O.B. _____

SOCIAL SECURITY# _____ PHONE# _____ MALE _____ FEMALE _____

LOCAL ADDRESS _____

MAILING ADDRESS _____

FATHER'S NAME _____ SOCIAL SECURITY# _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

WORK PHONE _____ DRIVER'S LICENSE# _____

MOTHER'S NAME _____ SOCIAL SECURITY# _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

WORK PHONE _____ DRIVER'S LICENSE# _____

PERSON TO CONTACT IN EMERGENCY _____

HOME PHONE _____ WORK PHONE _____

RELATIONSHIP _____

INSURANCE CO. NAME _____

SUBSCRIBERS NAME _____

SUBSCRIBER SS# _____ D.O.B. _____

CLAIMS MAILING ADDRESS _____

GROUP# _____ COPAY _____

RELATIONSHIP TO PATIENT _____

REFERRED BY _____

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL INSURANCE BENEFITS OTHERWISE DUE ME TO ARTURO QUINTANILLA, MD, FOR ALL SERVICES RENDERED BY HIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY SAID INSURANCE. I ALSO AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENTS. IF COLLECTION ACTION BECOMES NECESSARY TO COLLECT BALANCE DUE, I WILL PAY ANY COLLECTION COSTS AND/OR ASSOCIATED ATTORNEY FEES. ALSO, I HAVE RECEIVED, UNDERSTAND AND ACCEPT THE PRACTICE POLICIES STATEMENT FROM ARTURO QUINTANILLA, MD.

SIGNATURE _____ DATE _____