



HI-CARE MEDICAL CENTER

2001 ZINFANDEL DR. SUITE B-3
RANCHO CORDOVA CA 95670

PHONE: (916) 638-5572
FAX: (916) 638-5538

PATIENT INFORMATION

DATE HOME PHONE

DOB CELL PHONE

NAME (LAST, FIRST) PATIENT ID

ADDRESS

CITY STATE ZIP CODE SEX

MARITAL STATUS: MARRIED SEPARATED DIVORCED SINGLE WIDOWED MINOR

EMPLOYER

EMPLOYER ADDRESS

PARENT OR SPOUSE NAME PHONE NUMBER

IN CASE OF EMERGENCY (NAME) PHONE NUMBER

ADVANCE DIRECTIVE YES No DATE INITIALS

INSURANCE INFORMATION

INSURANCE COMPANY SOCIAL SECURITY

PRIMARY INSURANCE: MEDICARE MEDICAL PPO HMO OTHER

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDANT(S), HAVE INSURANCE COVERAGE WITH AND ASSIGN DIRECTLY TO DR. ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY (IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

SIGNATURE OF PATIENT DATE

PLEASE PRINT NAME OF PATIENT/ GUARDIAN OR REPRESENTATIVE DATE