JESSICA ADKINS, M.D.

415 Rolling Oaks Dr. Suite #260
Thousand Oaks, CA 91361
(805) 908-0100

PATIENT INFORMATION

PLEASE PRINT

PATIENT	Mr. Mrs. Miss/Mrs.	Last	First	MI	Home Phone:
Patient's Home Address			City	State	Zip
Patient Email Address			Cell Phone:		
Social Security #:	Date of Birth	Age	Sex	Driver's License #:	
Patient's Employer	Work Address			Work Phone:	
Spouse's Name	Spouse's Employer (Name & Address)			Work Phone:	
Emergency Contact: (Local/Relative/Friend)	Name	Address		Phone:	

REFERRED TO THIS OFFICE BY: _____

INSURANCE	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:		
PRIMARY:	Name	Policy #	Subscriber
	Insurance Address		Subscriber D.O.B.
SECONDARY:	Name	Policy #	Subscriber
	Insurance Address		Subscriber D.O.B.

RESPONSIBLE PARTY	Mr. Mrs. Miss/Mrs.	Last	First	D.O.B.
Address			Phone	
Occupation	Employers Name & Address		Bus. Phone:	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

METHOD OF PAYMENT: CASH _____ CHECK _____ CREDIT CARD _____

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical / surgical benefits to ***Jessica Adkins,M.D.,*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____