RMC Rocha MEDICAL CLINIC

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Patient Demographics:

Date: (mm/dd/yy): _____

Patient Information: First: _____ MI: _____ Last: _____ Date of birth _____/_____/_____ Age _____

Sex: M F Marital status: Married Single Widow Divorced Home Tel #: (_____) _____ Social sec #: _____

Address: _____ City: _____ State: _____ Zip: _____

Driver's license:#: _____ State: _____ Cell #: _____ E-mail: _____

Billing Address: ( ) same _____ **Language:** [ ] Spanish, [ ] English, [ ] Other

Race: [ ]Asian, [ ] Black, [ ] Caucasian, [ ]Caucasian Hispanic, [ ] Other **Ethnicity**: [ ] Hispanic, [ ] Non Hispanic, [ ] Declined

How would you like to have your medical information explained to you? [ ] spoken [ ] written [ ] no preference [ ] if spoken, what language _____

Emergency Contact: Name (Last, First)**:** _____ Phone Number: _____

Employer: Employer: _____ Employer's Address: _____

Work Telephone #: _____ Address: _____

Spouse / Significant Other Information: Name (Last, First): _____

Social Security: _____ Age: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Tel #: _____ Cell Tel #: _____ Work Tel #: _____

If minor: Parent / Guardian's name: _____ Tel #: _____ Relation to patient: _____

Insurance Primary Carrier: Type: □ Private Insurance Co., □ HMO, □ PPO, □ POS,

Insurance Co: _____ **Per Visit Co-pay** _____ Phone #: _____

Ins Co Address: _____ City: _____ State: _____ Zip: _____

Insurance Co. Tel #: _____ Lab Co-Pay: _____ Annual Deductible: _____

Employer of policy holder: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's Soc Sec #: _____

Medicare / Medicaid Information: Medicare #: _____ Part A: _____ Part B: _____

Date of eligibility: _____ Medicaid Number: _____ Effective date: _____

Medicaid HMO Plan: _____ Primary Care Physician: _____

Who were you referred by? _____ How did you hear about us? _____

Payment Policy

I understand that I am ultimately responsible for any balance that accumulates and agree to pay any balance due after insurance paid or responded.

Authorization of Payment

I hereby authorize Guillermo Rocha, MD to release medical information concerning my examination and/or treatment for insurance purposes and receive direct payment for any medical benefits payable to me for services rendered.

Acknowlegement- Review of Notice of Privacy Practices

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature: _____ Date: _____