

JEROME R. POTOZKIN, M.D. & MONICA K. BRAR, M.D.

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TEL (925) 838-4900 FAX (925) 838-4920

Referred By: _____ E-Mail Address: _____

PATIENT INFORMATION

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Full Legal Name: _____ Maiden Name: _____
Last First MI

Address: _____
Street City State Zip Code

Age: _____ Birth Date: _____ Marital Status: _____ Social Security #: _____

Is patient a minor? Yes No Parent/Guardian: _____ Relation: _____

Patient Employed By: _____ Occupation: _____

Employer's Address: _____
Street City State Zip Code

Emergency Contact: _____ Relation to patient: _____ Phone: _____

Person Responsible for Account: _____ Relation to patient: _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____ Social Security: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

SECONDARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____ Social Security: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

PATIENT SIGNATURE

I, certify that I (or my dependent) have insurance coverage with _____ Insurance Company and assign insurance benefits directly to Dr. Potozkin, 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.

Patient Signature

Relationship

Date

↓ For Staff Use Only ↓

Staff Initials: _____ Date: _____
Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____
Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____
Staff Initials: _____ Date: _____

Male
Female