DANESH MEDICAL GROUP
URGENT AND PRIMARY CARE

31581 Canyon Estates Dr.
Lake Elsinore, CA 92532
Phone: 951-244-3500
Web: www.daneshmedical.com

Today's Date:_____

Thank you for choosing our office. In order to serve you properly we will need the following information.
You may print this form and write on it or fill it out on your computer then print and bring to our office.

Patient's Name:	Home Phone:	Birth date:	Marital Status:
Residence Address:	City:	State:	Zip:
If patient is a child, parent/guardian name:	Address if Different:		
Social Security Number:	Cell#:	Driver' License #:	
Name of Employer/ Occupation	Business Address:	Business Phone:	
Do you have medical insurance?:	If no, how do you intend to pay?		
Insurance company name & address:			
Subscriber name:	Policy#:	Is this through your employer?	
Name of spouse:	Birth date:	Social Security #:	
Name and address of spouse's employer:	Business phone:		
Is there secondary insurance?	Insurance company name & address:		
Policy #:	Medicaid #:	Medicare #:	
Worker's Compensation?:	Name & address of company:		
Company phone:	Treatment authorized by:		
Person responsible for this account:			
Self or Other:	Address:		
Nearest friend or relative not residing with you:	Relationship to patient:	Phone:	
If patient is a child, who may	Relationship	--	
Nearest friend or relative not residing with you:	Relationship to patient:	Phone:	
If patient is a child, who may authorize treatment?:	Relationship to child:	Phone:	
Whom should we thank for referring you?:	Address:		
Do you authorize release of your medical information to anyone besides your insurance carrier?:	If so, whom?:		
Do you have a telephone answering machine in your home?	If yes, may we leave message from this office on that machine?:		

* I authorize this office to release to the named insurance company any information necessary to expedite insurance payment.
I understand that I am responsible for all charges, regardless of insurance coverage.
Please, be advised there is a 15% interest applied to accounts OVER 60 days old. In an event of collection, patient will be responsible for the collection fees. ALL telephone conversation to and from this office are recorded.

Patient, Parent/Guardian Signature_____