CLAREMONT
MEDICAL CENTER

PATIENT INFORMATION

Patient's Name:_____Age:_____Date of Birth_____

Sex:_____Home Address: _____

City:_____Zip Code_____Home Phone: _____

Cell Phone:_____Work Phone:_____Email:_____

Marital Status: Single_____Married_____Widowed_____Separated_____Divorced _____

Social Security No.:_____

Ethnicity (optional): Hispanic ____ Caucasian ____ African American____Asian_____Other_____

Emergency Contact

Name:_____Relationship: _____

Phone:_____Cell:_____Work Ph:_____

Responsible Party Information (Spouse, Parent, Self)

Name:_____DOB: _____

Relationship_____Address: _____

City:_____Zip Code_____

Cell Phone:_____Work Phone_____

Insurance Information (Don't fill if insurance card is present)

Insured Party:_____Relationship to Patient: _____

1st Insurance Company: _____Phone: _____

Address:_____City: _____

Zip Code_____Policy No:_____Group No: _____

2nd Insurance Company:_____Phone:_____

Address:_____City: _____

Zip Code_____Policy No:_____Group No: _____

Medical Records: Authorization is hereby granted for release of any information required to process this claim. A copy of this is valid as the original.

Consent to Treatment: I hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my physician, he/she shall not be liable for the consequences of such decision.

Patient's Signature_____Date: _____