

South Bay Sports & Preventive Medicine Associates, Inc.

455 O'Connor Drive #150, San Jose, CA 95128
2039 Forest Avenue #204-A, San Jose, CA 95128

DATE: _____

Patient's Name: _____ Gender M F

Birthdate: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone # () _____ Cell # () _____

Marital Status: Married Single Widowed Divorced

Emergency Contact Name and Number: _____ Relationship _____

Patient's Employer: _____ Occupation: _____

Employer's Address _____ City _____ State: _____ Zip _____

Work Phone # () _____ Best Phone # to Call You: Home Work Cell

INSURANCE: PRIMARY (Self/Spouse/Parent)

INSURANCE: SECONDARY (Self/Spouse/Parent)

Insurance Name: _____

Insurance Name: _____

Insured Name: _____

Insured Name: _____

Birthdate: _____

Birthdate: _____

I.D. # / Policy # _____

I.D. # / Policy # _____

Group/Plan # _____

Group/Plan # _____

Effective Date: _____

Effective Date: _____

ASSIGNMENT AND RELEASE

I understand I am financially responsible for co-payments, deductibles, co-insurance percentages (initials)
And any non-covered services by my health plan **AT TIME OF SERVICE.** _____

I authorize the physician to release any medical information required in order for claim processing. _____

I hereby authorize my insurance benefits to be paid directly to the undersigned physician. _____

Signed: _____ Date _____

THANK YOU!