☐ Walter C. Martinez, M.D., F.A.A.N.
☐ Carl H. Sadowsky, M.D., F.A.A.N.
☐ Jose A. Zuñiga, M.D.
☐ Paul K. Winner, D.O., F.A.A.N.

☐ Reed Stone, M.D., F.A.A.N.
☐ Edwin C. Wingkun, M.D.
☐ Louis J. Butera, D.O.

PATIENT INFORMATION:

Date: _____

Last Name _____ **First Name** _____ **Middle Name** _____

SEX: ☐M ☐F **Marital Status:** ☐S ☐M ☐D ☐W **DOB:** _____ **Social Security #:** _____

Mailing Address | **City** | **State** | **Zip Code**

Alternate Address | **City** | **State** | **Zip Code**

Home Phone | **E-Mail** | **Cell Phone**

Place of Employment | **Work Phone**

Work Address | **City** | **State** | **Zip Code**

Phone | **UPIN #**

REFERRING DOCTOR

Address | **City** | **State** | **Zip Code**

PARENTAL INFORMATION

Information is needed on the parent who is insured.
If there is no insurance, then information is needed on the financially responsible parent.

Last Name _____ **First Name** _____ **Middle Name** _____

SEX: ☐M ☐F **Marital Status:** ☐S ☐M ☐D ☐W **DOB:** _____ **Social Security #:** _____

Place of Employment | **Work Phone**

Work Address | **City** | **State** | **Zip Code**

SPOUSAL INFORMATION

Last Name _____ **First Name** _____ **Middle Name** _____

DOB: _____ **Social Security #:** _____

Place of Employment | **Work Phone**

Work Address | **City** | **State** | **Zip Code**

INSURANCE INFORMATION

PRIMARY:

NAME OF THE INSURED | **I.D. # OR POLICY #** | **GROUP#**

INSURANCE COMPANY | **Phone**

Address | **City** | **State** | **Zip Code**

TYPE OF INSURANCE: ☐HMO ☐PPO **REFERRAL / AUTHORIZATION NEEDED?** _____

SECONDARY INSURANCE

NAME OF THE INSURED	I.D. # OR POLICY #		GROUP#
INSURANCE COMPANY			Phone
Address	City	State	Zip Code

EMERGENCY CONTACT:_____ **PHONE:** _____

I hereby authorize payment directly to Drs. Martinez, Sadowsky, Zuñiga, Stone, Winner, Wingkun and / or Butera of the medical and / or surgical benefits otherwise paid to me but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNATURE: _____

I hereby authorize payment directly to Drs. Martinez, Sadowsky, Zuñiga, Stone, Winner, Wingkun and / or Butera to release my insurance company and / or Primary Care Physician any information acquired, including diagnosis and records in the course of my examination or treatment.

SIGNATURE: _____

I hereby authorize any doctor, hospital or medical facility to release records to Drs. Martinez, Sadowsky, Zuñiga, Stone, Winner, Wingkun and/or Butera.

SIGNATURE: _____

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISIT BE PAID AT THE CONCLUSION OF EACH VISIT.

YOU WILL BE PAYING BY: ☐ **CHECK** ☐ **CASH** ☐ **ALL MAJOR CARDS ACCEPTED**