

South Bay Sports & Preventive Medicine Associate, Inc.

455 O'Connor Drive #150, San Jose, CA 95128

Date: _____

Patient's Name: _____

Gender: Male / Female

Birthdate: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone # () _____ Cell# () _____

Email Address _____

Marital Status: Married Single Widowed Divorced

Emergency Contact Name & Phone # _____ Relationship _____

Patient's Employer: _____ Occupation: _____

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

Work Phone # () _____ Best Number to reach 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 claim processing. _____

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

Signed _____ Date _____

Thank You!