

# ARTHRITIS & OSTEOPOROSIS MEDICAL CENTER

5451 La Palma Ave #25   
La Palma, CA 90623

2063 S. Atlantic Blvd. #300  
Monterey Park CA 91754

Date \_\_\_\_\_ (Please Print)

## PATIENT INFORMATION

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Home Phone # ( ) \_\_\_\_\_

OK to leave voice mail? Please check one box yes no

Address \_\_\_\_\_

Cell Phone # ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

OK to leave voice mail? Please check one box yes no

Driver's License # or State ID # \_\_\_\_\_

Primary contact number  Home  Cell

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birth date \_\_\_\_\_

Desired method of contact (please check all that apply)

Married  Widowed  Single

Voice  Text  Email

Separated  Divorced

Height \_\_\_\_\_ Weight \_\_\_\_\_

Patient Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Referring Physician \_\_\_\_\_

Occupation \_\_\_\_\_

Physician Phone # ( ) \_\_\_\_\_

Employer Phone # ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone # ( ) \_\_\_\_\_

Your relationship to emergency contact \_\_\_\_\_

**From time to time we may ask you if we can take a picture of you to include in your chart, related to the condition you may be treated for, please check one of the boxes below with your desired directive and sign. Thank you.**

Yes I consent  No I do not consent

Patient Signature \_\_\_\_\_

## INSURANCE AUTHORIZATION RELEASE

Please read and complete the following to allow the Arthritis & Osteoporosis Medical Center to submit claims to and receive reimbursement from your insurance for medical services provided. Please note: If the patient is not the insured member, both the patient and the insured member must sign below.

Is the patient the insured?  Yes  No **If you checked no, please fill out insured information line below**

Insured Name \_\_\_\_\_ Insured D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

By signing below, I hereby authorize \_\_\_\_\_ Insurance Company to assign all medical benefits to which I am entitled, and make payment directly to:

**Arthritis & Osteoporosis Medical Center  
Attn: Accounts Receivable  
5451 La Palma Avenue, Suite 25  
La Palma, California 90623**

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the Arthritis & Osteoporosis Medical Center to release all information necessary to secure payment for medical services rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date