Oscar T. Ortiz, M.D. Ronald B. Villanueva, M.D. Francisco D. Cruz, M.D.
Ahmet S. Can, M.D. Leslie Taguba-Madrid, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

(PLEASE PRINT CLEARLY)

Name: _____ Social Security #: ____-____-_____
(Last) **(First)** **(Middle Initial)**
Address: _____ Apt. # _____
City: _____ State _____ Zip _____
Home Phone: (_____)_____-_____ Work Phone: (_____)_____- _____
Cell Phone: (_____)_____-_____ Email Address: _____
Date of Birth: _____ Sex: (M / F) Marital Status : (S / M / W / D)
In Case of Emergency Contact: _____ Phone: (_____)_____- _____
Purpose of visit or Diagnosis: _____
Referring Physician's Name: _____Phone (_____)_____-_____
Primary Care Physician: _____ Phone (_____) _____-_____
Pharmacy: _____ Phone (_____)_____- _____
Employer Name: _____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Ins. Co. Name:_____	Ins. Co. Name: _____
Policy #: _____ Group # _____	Policy #: _____ Group # _____
Relationship to Patient: _____	Relation to Patient: _____
Insured Name : _____ ___	Insured Name : _____
Insured Date of Birth: _____ M / F	Insured Date of Birth: _____ M / F
Insured SS#: _____-_____-_____ ___	Insured SS#: _____-_____-_____

To protect patient confidentiality, we will only disclose your medical information as you instruct us to. Please answer the following:

May we leave message on your answering machine with the appointment time?_____Yes _____ No
May we leave messages on answering machine about medication changes? _____ Yes _____ No
May we call you at work? _____ Yes _____ No
What family member may we discuss your medical condition with?
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

I have read the Office Policies: _____
(Sign)

I hereby authorize my insurance company benefits to be paid directly to **Oscar T. Ortiz, MD PC.** I realize I am responsible to pay any non-covered services, co-payment and co-insurance. I hereby authorize the release of pertinent medical information to the insurance company. I also realize that if my insurance plan requires referral, I am responsible to have a valid referral at every office visit. If for any reason my insurance does not cover services rendered, I am responsible for payment in a timely manner.

_____
(Signature)

Revised 7/1/13 mog