

Patient Information Form

(page 1 of 2)

(Please Read Carefully and Print Legibly)

Today's Date: _____

Date of Last Visit: _____

Patient:

Name (Last): _____ First: _____ M.I. _____

Age: _____ Date of Birth: _____ Soc Sec # _____ - _____ - _____

Sex: _____ Male _____ Female Marital Status: _____ Single: _____ Married: _____ Divorced

Address _____ City: _____ State: _____ ZIP _____

(Please circle preferred phone number to be contacted at below):

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

E-Mail: _____

Employer/School _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP _____

Insurance:

Primary Insurance Company: _____

Address: _____ City: _____ State: _____ ZIP _____

Insured Name (Last): _____ (First) _____ (M.I.): _____

Relationship (i.e. Wife, Husband, Parent): _____ Date of Birth: _____

ID/Group/Coverage Numbers: _____

Secondary Insurance Company: _____

Address: _____ City: _____ State: _____ ZIP: _____

Insured Name (Last): _____ (First): _____ (M.I.): _____

Relationship (i.e. Wife, Husband, Parent): _____ Date of Birth: _____

ID/Group/CoverageNumbers: _____

Our Relationship with You: (How did you hear about us?)

Doctor Referral (please include name): _____

Friend _____ Relative _____ YellowPages _____ Website _____ Internet _____ Other _____

May we contact you via email about your next appointment? _____ Yes _____ No

Have you visited our website at www.drjonscottdo.com? _____ Yes _____ No

Patient Information Form

(2 of 2)

(Please Read Carefully)

TERMS:

SORRY, WE DO NOT ACCEPT MEDICARE OR MEDI-CAL PATIENTS

INSURANCE: YOU ARE RESPONSIBLE FOR UNDERSTANDING THE GUIDELINES AND REQUIREMENTS OF YOUR INSURANCE COMPANY. IF YOU ARE NOT SURE OF THE REQUIREMENTS OF YOUR INSURANCE COMPANY, PLEASE CHECK WITH THEM PRIOR TO OBTAINING MEDICAL SERVICES. Please note that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

PAYMENT: CASH PAYING PATIENTS AND COPAYS MUST BE PAID AT THE TIME OF SERVICE. CASH, CREDIT CARD AND PERSONAL CHECKS ARE ACCEPTED. NOTE: THERE WILL BE A \$25.00 CHARGE FOR ALL RETURNED CHECKS.

APPOINTMENTS: PLEASE NOTIFY US AT LEAST 24 HOURS IN ADVANCE OF ANY CANCELLATIONS OR RESCHEDULING OF YOUR APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A \$25.00 CHARGE. YOU ARE RESPONSIBLE FOR REMEMBERING YOUR APPOINTMENT TIME. WE DO CALL TO CONFIRM YOUR APPOINTMENT.

ASSIGNMENT: I, THE UNDERSIGNED HAVE INSURANCE COVERAGE WITH AND ASSIGN DIRECTLY TO DR. SCOTT MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

RESPONSIBILITY: I, THE UNDERSIGNED UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

RELEASE: I, THE UNDERSIGNED, HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

We value your business and thank you for the opportunity to serve you.
Please sign and return to the receptionist.

SIGNED: _____ DATE: _____

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