Luis G. Ramirez, M.D.
PATIENT INFORMATION

PATIENTS NAME:_____
LAST NAME FIRST NAME MIDDLE INTIAL

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY NUMBER:_____

SEX: ☐ F ☐ M MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

HOME ADDRESS:_____
STREET ADDRESS CITY STATE ZIP CODE

TELEPHONES:_____ _____ _____
HOME CELLULAR WORK

E-MAIL ADDRESS:_____

PLACE OF EMPLYMENT:_____OCCUPATION:_____

ADDRESS:_____ TELEPHONE:_____

SPOUSES NAME:_____GUARDIAN'S NAME(IF MINOR):_____

PLACE OF EMPLOYMENT:_____OCCUPATION:_____

ADDRESS:_____ TELEPHONE:_____

LANGUAGES SPOKEN BY PATIENT:_____

PRIMARY INSURANCE:_____POLICY #:_____GROUP #:_____

ADDRESS:_____ TELEPHONE:_____

NAME OF INSURED:_____DATE OF BIRTH:_____

SECONDARY INSURANCE:_____POLICY #:_____GROUP #:_____

ADDRESS:_____ TELEPHONE:_____

NAME OF INSURED:_____DATE OF BIRTH:_____

EMERGENCY CONTACT:_____
NAME RELATIONSHIP TELEPHONE

MEDICAL ALLERGIES:_____

PRIMARY CARE PHYSICIAN:_____TELEPHONE:_____

I, HERBY AUTHROIZE MY DOCTOR, AND/OR HIS ASSOCIATES, TO APPLY FOR BENEFITS TO MY INSURANCE COMPANY ON MY BEHALF FOR SERVICES PROVIDED TO ME. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO MY PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY ANY CHARGE NOT REIMBURSED BY MY INSURANCE COMPANY. I AGREE TO BE RESPONSIBLE FOR ANY RESONABLE FEES INCURRED IF I SHOULD BECOME DELIQUENT IN PAYMENT OF MY ACCOUNT AND IT MUST BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY.
WITH MY APPROVAL AND KNOWLEDGE, THE ABOVE NAMED PHYSICIAN AND/OR HIS ASSOCIATES ARE AUTHORIZED TO PERFORM ANY MEDICAL TEST NECESSARY TO DETERMINE PROPER DIAGNOSIS AND TREATMENT.

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SIGANTURE OF APTIENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE DATE