TUSTIN IRVINE INTERNAL MEDICINE GROUP, INC.

PATIENT INFORMATION

MARIO S. FICAROLA, M.D., INC.
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TUSTIN, CA 92782
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(Please Print)

Today's date:			Physician:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
(Former name if any):	Religion:	Driver's License No.	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Spouse name:	Spouse DOB: / /	Insurance subscriber:			DOB: / /	
Street address:		Social Security no.:			Home phone no.: ( )	
City	State:	ZIP Code			Cellular phone no.: ( )	
Occupation:	Employer (and address):				Employer phone no.: ( )	
Chose TIIMG because/Referred to TIIMG by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Other			
Other family members seen here:		Relationship:				

INSURANCE INFORMATION

Please bring your insurance card with you to each appointment.

IN CASE OF EMERGENCY

Emergency contact (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I hereby assign my insurance benefits to be made directly to my physician and/or his associates for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I also agree to pay all co-payments, co-insurances and/or elective service fees at the time provided. If there are problems collecting payments from me I agree that I will also be liable for attorney's fees, collection agency costs or any related fees and they will be added to my bill.

I authorize the release of all information to other physicians and insurance carriers requested for the purpose of payment for medical services and further treatment by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby agree that I have read, understand and agree to hereby give consent for treatment.

_____ _____

Patient/Guardian signature *Date*