



AZUSA
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 Azusa, CA 91702
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LANCASTER
 44303 N. Lowtree Ave.
 Lancaster, CA 93534
 Ph: 661-940-5494
 Fax: 661-940-0825

SHERMAN OAKS
 4940 Van Nuys Blvd., Ste. 301
 Sherman Oaks, CA 91403
 Ph: 818-907-0952
 Fax: 818-990-9449

PATIENT INFORMATION **EMAIL ADDRESS:** _____

Last Name:		First Name:		Middle Initial:	Date: / /	
Address:			City:		State:	Zip:
Birth date: / /	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	S.S. #: / /		
Home Phone: () -		Alternative Phone (Cell): () -		Spouse:		
Chose Clinic Because / Referred to clinic by		<input type="checkbox"/> Dr:	<input type="checkbox"/> Insurance	<input type="checkbox"/> Family	<input type="checkbox"/> Friend	
<input type="checkbox"/> Former Patient	<input type="checkbox"/> Close to Work/Home	<input type="checkbox"/> Website	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:		

WORK INFORMATION

Employer:		Work Phone () -		Ext:		
Occupation:	Employment status:		<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Retired	<input type="checkbox"/> Not Employed

CARE PROVIDER INFORMATION

Referring Dr:	Referring Dr. Phone: () -
Regular Dr./PCP	Regular Dr./PCP Phone: () -

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Name:

Subscriber's Name (If different):	Birth date: / /
ID #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

Name of Secondary Insurance:

Subscriber's Name (If different):	Birth date: / /
ID #:	Group/Policy #
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:	

AUTO or WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: <input type="checkbox"/> Auto:		<input type="checkbox"/> Worker's Comp:			
Adjustor/Claim Manager:		Phone # () -		Ext:	
Address:		City:		State:	Zip:
Claim #:	Accident Date:		Cause:		

ATTORNEY INFORMATION

Name:		Law Firm:		Phone # () -	
Address:			City:		State: Zip:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: () -	Work Phone: () -

I authorize my insurance benefits be paid directly to South Pacific Rehab. Services. I understand that I am financially responsible for any unpaid balance. I also authorize _____ to release any information required to process my claims.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____