PATIENT AND INSURANCE INFORMATION

Please bring or provide a copy of your driver's license and insurance cards.

Patient's Name: ______________________________ DOB: ___/___/____ Age: ___________ Gender: ☐ M ☐ F

Address: ____ City: ____________________ State: _____ Zip: _____

Home#: ______________________ Cell #: ________________________ Work#:___________________________

SSN #: ___________________________________ Driver's License #: ____________________________________

E-mail: ____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse Name: ________________________________

Employer: ___________________________________ Occupation: ______________________________________

Primary Care Provider: __________________________ Phone #____

Emergency Contact: ___________________________________ Phone #: _________________________________

INSURANCE INFORMATION

PRIMARY:

Insurance Company: ____________________________ Policy #: _______________ Group #:________________

Subscribers Name: _____________________________ Social Security #: _______________ DOB: _____________

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________________________

SECONDARY:

Insurance Company: ____________________________ Policy #: _______________ Group #:________________

Subscribers Name: _____________________________ Social Security #: _______________DOB:_____________

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________________________

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Assignment of Benefits: It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The patient/guarantor is responsible for deductibles, co-pays, non-covered services, other services that are not considered medically necessary, as well as any other fees in accordance with insurance contracts. I hereby assign all medical benefits to which I am entitled. I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Trina Health of Sacramento.

I hereby acknowledge that I am fully responsible for payment as listed above.

Signed:____ Date: ____________________________

TRINA HEALTH