



30110 Crown Valley pkwy #101 Laguna Niguel, Ca 92677 T (949) 495-7144 F (949) 495-0270

www.lagunaniguelmedical.com

Patient Information

Patient Name: _____ Home Phone: _____

Address: _____

City/State/Zip: _____

Birthdate: _____ Age: ____ Male Female Single Married Divorced Widowed

Social Security #: _____ Driver's License #: _____

Employer: _____ Business Phone: _____

Business Address: _____

City/State/Zip: _____

Occupation: _____

Insurance Information

Primary Insurance: _____ Private PPO POS HMO

Name of Insured: _____ Relationship to Patient: _____

Insured Social Security #: _____ Insured Date of Birth: _____

Group Policy #: _____ ID#: _____ Customer Service # _____

Secondary Insurance: _____ Private PPO POS HMO

Name of Insured: _____ Relationship to Patient: _____

Insured Social Security #: _____ Insured Date of Birth: _____

Group Policy #: _____ ID#: _____ Customer Service # _____

Person to notify in case of Emergency: _____ Relationship to Patient: _____

Address: _____ Phone #: _____

Assignment of Benefits

I hereby authorize and direct my insurance carrier to pay directly to Laguna Niguel Family Medical Center benefits due me out of the terms of my policy issued by your company. Payment is authorized upon receipt of an itemized statement or claim form for services rendered to me. My policy was in full force and effective at the time these services were rendered. I also acknowledge that I am fully responsible for all co-payments, deductibles and any charges not covered by my insurance at the time of service. I agree to notify you immediately of any changes in my health status or the above information

Authorized Signature: _____ Date: _____