CONFIDENTIAL PATIENT **INFORMATION** Gateway Medical Group of San Diego, Inc

Last Name	First Name	MI	Birth Date	Primary Location	Today's Date

Address	City	State	Zip Code	MRN

Home Phone: Work Phone:	Mobile Phone: Email:	Gender	Social Security #

Language:
Please select one:

□ English □ Greek □ Vietnamese
□ Spanish □ Italian □ Tagalog
□ French □ Japanese □ Russian
□ Arabic □ Korean □ Cambodian
□ Chinese □ Mandarin □ Laotian
□ German □ Persian □ Other

Race:
Please select one race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Additional Race:
Please select one additional race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Ethnicity
Hispanic or Latino*- A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race.* ***Please select:***

□ Hispanic or Latino □ Non-Hispanic or Latino
□ Decline to answer □ Unknown

Marital Status:	Patient Acct

Employer:
Employer Address:

Name of Emergency Contact	Home Phone	Work Phone	Relationship to Patient

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient	

Address	City	State	Zip Code

Home Phone: Work Phone:	Social Security #	Birth Date	Gender

Employer's Name	Employer's Address:

PRIMARY INSURANCE

Insurance Name:	
Claims Address	CoPay
City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.
Subscribers Birth Date	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

SECONDARY INSURANCE

Insurance Name:	
Claims Address	CoPay
City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.
Subscribers Birth Date	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

I authorize payment of my medical benefits be made directly to my physician for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information necessary related to my medical care and to facilitate payment of my medical expenses owed my physician. ***Initials:*** _____

I, the patient or Legal guardian, acting in behalf of the patient listed above, hereby consent to Physical examinations, Diagnostic tests (e.g. Blood, skin, urine test, etc.) and non-surgical medical treatments of the condition diagnosed for the above patient to be performed by Physicians, Physician Assistant, Nurse Practitioner or/and staff at Gateway Medical Group of San Diego, Inc. ***Initials:*** _____

_____ _____

SIGNED (Patient/Legal Guardian) ***DATE***