

Patient Information <i>Paciente</i>				
Last Name <i>Apellido</i> <i>Sexo</i>	First <i>Nombre</i>	MI <i>Initial</i>	Date of Birth <i>Fecha de Macimiento</i>	M/F
Mailing Address <i>Dirreccion</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip <i>Codigo</i>	SSN <i>Numero de Seguridad Social</i>
Physical Address <i>Dirreccion Phisical</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip <i>Codigo</i>	Driver's License # <i>Numero de Licensia de Manejar</i>
Patient Home Phone <i>Telefono</i> ()	Patient Work Phone <i>Telefono trabajo</i> ()	Patient Cell Phone <i>Telefono Cellular</i> ()		
Local Address and Phone (If Visiting)				
Employer or School Name and Address <i>Empleado Nombre y Dirreccion</i>				Occupation <i>Occupacion</i>
Marital Status S M W D Sep	Spouse's Name <i>Esposo/esposa?</i>		Spouse's Employer <i>Empleado de su esposa</i>	
Both Parents' Names (if patient is a minor) <i>Padres (si paciente es joven)</i>				Referred by
Emergency Contact Name <i>Alquien quien podemos contactor per emergencia</i>			Phone Number <i>Telefono</i> ()	Relation <i>Relacion</i>
Responsible Party Information (Complete only if patient is a minor) <i>Si es menos de 18 anos Los Padres completa</i>				
Last Name <i>Apellido</i>	First <i>Nombre</i>	MI <i>Initial</i>	Date of Birth <i>Fecha de Macimiento</i>	M/F <i>Seco</i>
Relationship <i>Relacion</i>	SSN <i>Numero de Seguridad Social</i>		Home Phone <i>Telefono</i> ()	Work Phone <i>Telefono trabajo</i> ()
Mailing Address <i>Dirreccion</i>			City <i>Ciudad</i>	State Zip
Employer Name and Address <i>Empleado Nombre y Dirreccion</i>				# of Years Employed
Method of Payment				
CASH		LOCAL CHECK		MASTERCARD/VISA
AUTHORIZATION FOR TREATMENT				
I, the undersigned, agree to medical treatment, diagnostic procedures, and health care services which may be administered by the physicians, the physician's assistants and/or their nurses or medical assistants.				
ASSIGNMENT OF INSURANCE BENEFITS				
I hereby authorize the direct payment of surgical/medical benefits to Aspen Medical Care for services furnished to me by the physician in person or under his/her supervision. If applicable, I hereby request that payment of authorized Medicare benefits be made on my behalf to Aspen Medical Care for services furnished to me by the physician in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby request that payment of authorized benefits be made to Aspen Medical Care on my behalf.				
Patient Signature <i>Firma</i> _____			Date <i>Fecha</i> _____	
Parent/Guardian Signature _____			Date _____	