Patient Information *Paciente*

Last Name *Apellido* | First *Nombre* | MI *Initial* | Date of Birth *Fecha de Macimiento* | M/F *Sexo*

Mailing Address *Dirrecion* | City *Ciudad* | State *Estado* | Zip *Codigo* | SSN *Numero de Seguridad Social*

Physical Address *Dirrecion Phisical* | City *Ciudad* | State *Estado* | Zip *Codigo* | Driver's License # *Numero de Licensia de Manejar*

Patient Home Phone *Telefono* ( ) | Patient Work Phone *Telefono trabajo* ( ) | Patient Cell Phone *Telefono Cellular* ( )

Local Address and Phone (If Visiting)

Employer or School Name and Address *Empleado Nombre y Dirrecion* | Occupation *Occupacion*

Marital Status S M W D Sep | Spouse's Name *Esposo/esposa?* | Spouse's Employer *Empleado de su esposo*

Both Parents' Names (if patient is a minor) *Padres (si paciente es joven)* | Referred by

Emergency Contact Name *Alquien quien podemos contactor per emergencia* | Phone Number*Telefono* ( ) | Relation *Relacion*

Responsible Party Information (Complete only if patient is a minor) *Si es menos de 18 anos Los Padres completa*

Last Name *Apellido* | First *Nombre* | MI *Initial* | Date of Birth *Fecha de Macimiento* | M/F *Seco*

Relationship *Relacion* | SSN *Numero de Seguridad Social* | Home Phone*Telefono* ( ) | Work Phone *Telefono trabajo* ( )

Mailing Address *Dirrecion* | City *Ciudad* | State | Zip

Employer Name and Address *Empleado Nombre y Dirrecion* | # 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 assistants and/or their nurses or medical assistants. I understand that, if I am prescribed schedule II through V drugs, my identifying prescription information will be entered into the PDMP database and may be accessed for limited purposes by authorized individuals.

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 by made to Aspen Medical Care on my behalf.

Patient Signature *Firma* _____ **Date *Fecha*** _____

Parent/Guardian Signature _____ **Date** _____