# ARTHRITIS & RHEUMATIC CARE CENTER

**PLEASE PRINT CLEARLY / Escriba claro, por favor**

PATIENT'S NAME
Nombre del paciente________________________________ SEX (circle) Sexo (marque) M F
Last (Apellido) First (Nombre) MI (Inicial)

SOCIAL SECURITY #
# de Seguro Social____________________ BIRTHDATE Fecha de nacimiento____________________

PERMANENT ADDRESS
Direccion permanente________________________________

CITY
Ciudad____________________ STATE Estado__________ Zip__________

HOME PHONE
Telefono de casa (______)____________________ CELL PHONE Telefono Celular (______)____________________

MARITAL STATUS (circle)
Estado civil (marque) S M D W DRIVER'S LICENSE # # de Licencia____________________

PATIENT'S OCCUPATION
Ocupacion del paciente________________________________

EMPLOYED BY
Empleo____________________ PHONE Telefono (______)__________ Ext.________

ADDRESS
Direccion____________________ CITY Ciudad__________ STATE Estado______ Zip__________

RESPONSIBLE PARTY / SPOUSE
Persona responsable / Esposo(a)____________________ PHONE Telefono (______)____________________

ADDRESS (If different from patient)
Direccion (Si diferente del paciente)____________________ CITY Ciudad__________ STATE Estado______ Zip__________

EMPLOYED BY
Empleo____________________ PHONE Telefono (______)__________ Ext.________

ADDRESS
Direccion____________________ CITY Ciudad__________ STATE Estado______ Zip__________

EMERGENCY CONTACT
Contacto de emergencia____________________ PHONE Telefono (______)__________ RELATIONSHIP Relacionado__________

REFERRED BY:
Referido por:____________________ PHARMACY PHONE Telefono de farmacia (______)____________________

**THIS SECTION MUST BE FILLED OUT - Es importante completar esta seccion:**

**INSURANCE-Seguro**

**PRIMARY INSURANCE**
**Su primer seguro____________________** **EFFECTIVE DATE Fecha de efectivo____________________**

**GROUP NUMBER**
**Numero de grupo____________________** **POLICY OR I.D. # # de poliza o identificacion____________________**

**NAME OF SUBSCRIBER**
**Nombre del asegurado____________________** **RELATION TO PATIENT Relacion con el paciente____________________**

**SUBSCRIBER'S BIRTHDATE**
**Fecha de Nacimiento del asegurado____________________**

**SECONDARY INSURANCE**
**Susegundo seguro____________________** **EFFECTIVE DATE Fecha de efectivo____________________**

**GROUP NUMBER**
**Numero de grupo____________________** **POLICY OR I.D. # # de poliza o identificacion____________________**

**NAME OF SUBSCRIBER**
**Nombre del asegurado____________________** **RELATION TO PATIENT Relacion con el paciente____________________**

**SUBSCRIBER'S BIRTHDATE**
**Fecha de Nacimiento del asegurado____________________**

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Arthritis & Rheumatic Care Center of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. I further agree that if this account is referred to an agency or attorney for collection, I will be responsible for collection costs, attorney's fees and court costs.

PATIENT'S SIGNATURE________________________________ DATE____________________