Olde Del Mar Surgical Medical Group, Inc. Patient Information

Date:_____________ **Dr. Sunil Bhoyrul**

LAST NAME (LEGAL)	FIRST NAME	MIDDLE INTIAL	DATE OF BIRTH
STREET ADDRESS	CITY/STATE	ZIP CODE	SEX M / F
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
EMPLOYER'S NAME	WORK ADDRESS	ZIP CODE	OCCUPATION
DRIVER'S LICENSE	MARITAL STATUS	RACE/ETHNICITY	RELIGIOUS PREFERENCE
REFERRING PHYSICIAN/ PHONE #		SOCIAL SECURITY# (Mandatory for Billing Insurance)	
PRIMARY CARE PHYSICAN		ADDRESS AND PHONE #	
NAME OF SPOUSE	PHONE #	DATE OF BIRTH	
EMERGENCY CONTACT	PHONE #	RELATIONSHIP	
PRIMARY INSURANCE	POLICY #	POLICY HOLDER/ DATE OF BIRTH	
SECONDARY INSURANCE	POLICY #	POLICY HOLDER/ DATE OF BIRTH	
PERFERRED PHARMACY	PHARMACY #	PHARM FAX#	

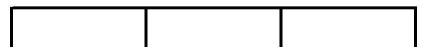
I consent to any medical treatment and/or physical examination required for myself or the minor named above for whom I am legally responsible. I authorize the release of ALL medical records for treatment, payment from insurance or other healthcare needs. A copy of this authorization to release medical records is as valid as the original. ____ Initials

Olde Del Mar Surgical (ODMS) cannot accept responsibility for any delayed claims or for negotiating a settlement on a disputed claim. I understand that I am fully responsible for any and all charges rendered at ODMS. A finance charge of 1.5% will be applied to balances due over 60 days. There will be a $15 charge for all returned checks.

I have received a copy of the HIPAA Notice of Privacy Practices Pamphlet. _____Initials

Signature ____________________________________ **Date: _________________**

updated 1/27/16



red at ODMS

updated 1/27/16