ARTHRITIS
CONSULTANTS OF NORTH COUNTY, A.P.C.

Patient Information

Patient Name _____ M / F Birthdate _____

Address _____

City _____ State _____ Zip _____

Phone Numbers - *Circle Best*

Cell _____ Home _____

Work _____ Email _____

Spouse or Partner _____ Birthdate _____

Medical Insurance (Primary) _____

(Secondary) _____

Please Present Insurance Cards at the time of Visit

Emergency Contact: _____ Phone: _____

Relationship _____

Assignment and Release

I, the undersigned, assign all medical benefits to the physicians at Arthritis Consultants of North County, APC. I also authorize release of any medical information to process my insurance claim. I will allow progress reports, labs, and x-ray results to be shared with my other physicians, unless otherwise specified.

Signature _____

Please Notify this office if there are any changes to the above.

ARTHRITIS CONSULTANTS OF NORTH COUNTY, A.P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

ARTHRITIS CONSULTANTS OF NORTH COUNTY

Privacy Officer 760-724-5800

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name of Patient: _____