PATIENT INFORMATION AND PAYMENT AGREEMENT

Telephone: 951-808-8863 Fax: 951-808-0550 www.pathcarefna.com

1810 Fullerton Avenue, Suite 102
Corona, CA 92881

41667 Ivy Street, Suite G
Murrieta, CA 92562

17451 Bastanchury Road, Suite 104C
Yorba Linda, CA 92886

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DOB	GENDER

NAME OF PERSON LEGALLY RESPONSIBLE (IF PATIENT IS MINOR)	MARITAL STATUS
HOME ADDRESS	HOME OR CELL PHONE NUMBER

E-MAIL ADDRESS	DRIVERS LICENSE NUMBER	OCCUPATION
EMPLOYED BY	BUSINESS ADDRESS	WORK PHONE
EMERGENCY CONTACT PERSON	CONTACT PERSON'S PHONE	RELATIONSHIP TO CONTACT PERSON
REFERRED BY	PRIMARY CARE PHYSICIAN	PCP PHONE

INSURANCE INFORMAITON

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
POLICY/GROUP NUMBER	POLICY/GROUP NUMBER
INSURED NAME	INSURED NAME
EFFECTIVE DATE	EFFECTIVE DATE

ASSIGNMENT OF BENEFITS:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits to which I am entitled to PathCare Diagnostics Inc. for any services rendered to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.
This assignment will remain effective until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

_____
DATE

_____
SIGNATURE OF PATIENT (OR LEGAL GUADIAN)

_____
WITNESS