Carmen Roman, M.D.
611 Veterans Boulevard, Suite 217
Redwood City, CA 94063
Fax: (650) 260-2953

Client Information

All information is held in strict confidence.

Please complete this form in black ink, sign and return to Carmen Roman, M.D. by mail or fax.

PATIENT INFORMATION

Name: _____ Date: ____/____/_____

Address: _____ City: _____ Zip: _____

Phone (Home): _____ Phone (Work): _____ Phone (Cell): _____

Social Security #: _____ Date of Birth: ____/____/_____ M: ___ F: ____

Employer: _____ Primary Physician: _____

Marital Status: _____ Spouse Name: _____

Do you have insurance coverage? __Y__ or__N__ Referred by: _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Phone (Home): _____ Phone (Work): _____ Phone (Cell): _____

Social Security #: _____ Date of Birth: ____/____/_____

Employer: _____

INSURANCE COMPANY INFORMATION

Primary Insurance Co: _____Phone: _____

Group #: _____ Subscriber#: _____ID#: _____

Have you met deductible? __Y__ or__N__

Secondary Insurance Co: _____Phone: _____

Group #: _____ Subscriber#: _____ID#: _____

IN CASE OF EMERGENCY PLEASE CALL:

Name: _____ Phone: _____

Assignment of Benefits/Release of Information

- I hereby authorize payment directly to Carmen Roman, M.D. of any medical benefits payable to me under the condition of my policy for services rendered. I hereby give consent for release to authorized persons of financial and medical information concerning care, treatment, and charges as may be required to complete all claims for benefit. Initials. _____
- l understand it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by insurance the day and time services are provided. Initials. _____
- I understand that I am responsible for all charges, regardless of insurance coverage. Initials. _____
- I understand that if I do not give 24 hours notice of cancellation I will be charged a $100.00 fee. Initials. _____

Signature: _____ Date: ____/____/_____