

INTAKE AND CONSENT

LUIS L. DIAZ, M.D.

DATE: _____ FULL NAME: _____ DOB: _____

SS #: _____ SEX: M / F EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL. WORK. HOME

SECONDARY PHONE: _____ CELL. WORK. HOME

SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

RETIRED / STUDENT / EMPLOYED- EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE #: _____ CELL. WORK. HOME

PRIMARY INSURANCE

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURANCE NAME: _____ MEMBER #: _____

GROUP #: _____

SECONDARY INSURANCE

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURANCE NAME: _____ MEMBER #: _____

GROUP #: _____

AUTHORIZATIONS AND RELEASES:

I HEREBY AUTHORIZE PAYMENT OF **ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO LUIS L. DIAZ, MD.** ANY AND ALL COPAYS, CO-INSURANCES & DEDUCTIBLES FOLLOWING INSURANCE PAYMENTS ARE DUE AND PAYABLE BY MYSELF/LEGAL GUARDIAN. I ALSO REALIZE I AM RESPONSIBLE TO PAY ANY NON-COVERED SERVICES OR INSURANCE DENIALS.

SIGNATURE OF PATIENT/GUARDIAN: _____ RELATION: _____ DATE: _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTHCARE AND ANY **MEDICAL RECORDS REQUESTED** BY PHYSICIANS REGARDING MY HEALTH ADVICE, AND TREATMENT FOR THE PURPOSE OF **CONTINUING CARE.**

SIGNATURE OF PATIENT/GUARDIAN: _____ RELATION: _____ DATE: _____