JEROME R. POTOZKIN, M.D. & MONICA K. BRAR, M.D.

600 San Ramon Valley Blvd, Suite 102
Danville, CA 94526
925-838-4900
925-838-4920 Fax

PATIENT INFORMATION

Home Phone: ______________________ Work Phone: ______________________ Cell Phone: ______________________

Full Legal Name: ______________________________________ Maiden Name: ______________________
Last First MI

Address: ____
Street City State Zip Code

E-Mail Address: ______________________________ Referred By: ______________________________

Age: ______ Birth Date: ______________ Marital Status: ______ Social Security #: ______________________

Is patient a minor? ☐Yes ☐No Parent/Guardian: ______________________ Relation: ______________

Patient Employed By: ______________________________ Occupation: ______________________

Employer's Address: ____
Street City State Zip Code

Emergency Contact: ______________________ Relation to patient: ______________ Phone: ______________

Person Responsible for Account: ______________________________ Relation to patient: ______________

PRIMARY INSURANCE

Insurance Company: ______________________________ Effective Date: __________ Phone ______________

Address: ____
Street City State Zip Code

Subscriber's Name : ______________________________ ID#: ______________________ Group#: ______________

Relation to Patient: ______________ Birth Date: ______________ Social Security: ______________________

Subscriber's Employer: ______________________________ Occupation: ______________ Phone: ______________

Employer's Address: ____
Street City State Zip Code

SECONDARY INSURANCE

Insurance Company: ______________________________ Effective Date: __________ Phone ______________

Address: ____
Street City State Zip Code

Subscriber's Name : ______________________________ ID#: ______________________ Group#: ______________

Relation to Patient: ______________ Birth Date: ______________ Social Security: ______________________

Subscriber's Employer: ______________________________ Occupation: ______________ Phone: ______________

Employer's Address: ____
Street City State Zip Code

PATIENT SIGNATURE

I, certify that I (or my dependent) have insurance coverage with ______________________________Insurance Company and assign insurance benefits directly to Dr. Potozkin, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

______________________________ ______________________ ______________
Patient Signature Relationship Date

➜ For Staff Use Only ➜

Staff Initials: ______ Date: __________ Staff Initials: ______ Date: __________ Staff Initials: ______ Date: __________ Male

Staff Initials: ______ Date: __________ Staff Initials: ______ Date: __________ Staff Initials: ______ Date: __________ Female