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

600 San Ramon Valley Blvd. #102, Danville, CA 94526
TEL (925) 838-4900 FAX (925) 838-4920

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: _____

I give Dr. Potozkin permission to communicate with me via email: ☐ Yes ☐ No

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