LUIS F. PINEDA, M.D., P.C.

NEW PATIENT INFORMATION (Please Print) To be seen & established as a patient please complete all of the following.

Date ___________________________________ Referred by _____________________________________

NAME LAST FIRST MIDDLE

MARITAL STATUS-CHECK ONE

__Single __ Widowed __ Separated
__ Married __Divorced

ADDRESS

CITY	STATE	ZIP	EMPLOYER

AGE	DATE OF BIRTH	SOCIAL SECURITY #	DRIVER'S LICENSE #	STATE

E-MAIL ADDRESS	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**

SEX-CHECK ONE
__Male __Female

ETHNICITY-CHECK ONE
__ Hispanic on Latino
__ Not Hispanic or Latino

RACE-CHECK ONE
__Caucasian __Asian __ Other Pacific Islander __Other
__ Black __American Indian __ Hispanic __ Native Hawaiian

EMPLOYMENT-CHECK ONE
__F/T Employed __ P/T Employed __Retired __ Disability __ Unemployed __F/T Student __ P/T Student

If English is not preferred language indicate other language here ________________________________

PRIMARY INSURANCE POLICY INFORMATION	**SECONDARY INSURANCE POLICY INFORMATION**
Name of Insurance _______________________________	Name of Insurance _________________________________
Insured's Name ________________________________	Insured's Name ________________________________
Insured's Date of Birth __________________________	Insured's Date of Birth __________________________
Insured's Social Security # ________________________	Insured's Social Security # ________________________
Policy # _______________________________________	Policy # _______________________________________
Group # _________________ Eff. date ______________	Group # _________________ Eff. date ______________

PLEASE READ THE FOLLOWING CAREFULLY

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorized the Medical Practice to release any medical or other information about the patient which may be necessary for the proper filing of insurance claims, review of services or receipts of benefits.
ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorized direct payment of benefits to the Medical Practice. The undersigned also agrees to assist in processing all claims for benefits.
FINANCIAL RESPONSIBILITY: The Medical Practice strives to provide the best possible medical care for its patients. We expect that we will be paid for the services rendered. The undersigned agrees to be totally responsible for all charges for services rendered to the patient including any non-covered charges. The undersigned also agrees that if the unpaid account is referred to an attorney for collection, to pay all costs of collection, including reasonable attorney fees.

_______________________________________ _______________________________________

Patient (Agreement to Pay)

Guarantor (Agreement to Pay)
__ Spouse __ Power of Attorney __ Parent