# *Vanessa Shana Rothholtz, M.D., Inc.*

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***Patient Name:*** _____ ***Sex:*** _____

***Address:*** _____ ***Marital Status:*** _____

***City:*** _____ ***State:*** _____ ***Zip Code:*** _____

***Date of Birth:*** ____/____/____ ***Primary Language:*** _____

***Race:*** _____ ***Ethnicity:*** _____

***Social Security No:*** _____ ***Drivers License:*** _____

***Mark your primary number with an asterisk (*)*** ***( ) Cell Phone:*** _____

***( ) Work Phone:*** _____ ***( ) Home:*** _____

***May we leave a detailed message with results on your primary voicemail? ( ) Yes or ( ) No***

***Email Address:*** _____ ***Pharmacy Name/Number:*** _____

***Occupation:*** _____ ***Employer:*** _____

***Insurance Company:*** _____ ***I.D. No. / Medicare No:*** _____

***Insured Name:*** _____ ***Insured Date of Birth:*** ___/____/____

***Insured Social Security Number:*** _____ ***Relationship to insured:*** _____

***Whom shall we thank for referring you?*** _____

***Personal Physician:*** _____ ***Telephone:*** _____

***May we send your physician a report of our findings: ( ) Yes or ( )No***

***Emergency Contact:*** _____ ***Telephone:*** _____

***Relationship to Emergency Contact:*** _____

***<u>I authorize the release of medical information to my insurance company</u> ( ) Yes ( ) No***

***BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless your physician is contracted with your insurance carrier (including Medicare). The insurance company is hereby authorized to pay all benefits directly to my attending physician. If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager. We do not accept MediCal or legal liens.***

***I have read the above policy and understand my financial responsibility.***

***Date:*** _____ ***Signature:*** _____