Redlands Family Practice
A PrimeCare Provider

Henry M Chai, MD
Alexander Terrazas, MD
Maria Elena Terrazas, PA-C

Patient Information

Prefix (optional): □ Mr. □ Mrs. □ Ms.	Last Name:	First Name:		Middle initial (optional):	Date of birth:
Address:		City:	State:	ZIP code:	Home phone:
Driver's license number:		Social Security number:		Age:	Mobile phone:
Employer information (name):					
Business address:		City:	State:	ZIP code:	Work phone:
Emergency contact information: Name:			Home phone:		Mobile phone:
Name of spouse/partner (if any) or parent/legal guardian (if patient is a minor):			Relationship to patient:		

Primary health insurance:	Secondary health insurance (if any):
Member ID number:	Member ID number:
Group number:	Group number:
Subscriber name:	Subscriber name:
Subscriber ID number:	Subscriber ID number:
Subscriber's employer:	Subscriber's employer:

Please bring your health insurance card(s) and photo ID so we can make copies for our records.

I agree that:

1. Payments for services covered by Medicare or my medical group or health insurance can be paid directly to Redlands Family Practice Medical Group, Inc.
2. Redlands Family Practice Medical Group, Inc. can get or release my medical information to determine what services are covered or not covered by my health insurance.
3. My prescription drug plan can give my medication history to Redlands Family Practice Medical Group, Inc.
4. I may be responsible for paying for any services that aren't covered or are denied by my health insurance company.

Note: A copy of this form is as valid as the original.

_____ _____

Signature of patient (or responsible party): Date:

For office use. Scan date: _____

_____

Printed Name: