San Francisco Critical Care Medical Group, Inc.

Pulmonary/Critical Care/Sleep Disorders/Transplant Medicine
California Pacific Medical Center

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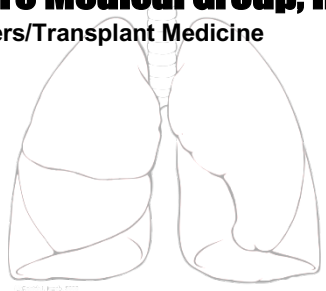

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Name: _____

Social Security Number:_____-_____-_____ **Birth date:**_____ **Age:**_____

Sex: (please circle) M F **Race:** (please circle) American Indian; White/Caucasian; Black/African American; Asian; Native Hawaiian/Pacific Islander; Hispanic; Other _____; Declined to State
Ethnicity: (please circle) Hispanic or Latino; Non-Hispanic nor Latino; Unknown; Declined to State

Language Preference: (please circle) English; Spanish; Chinese Mandarin; Chinese Cantonese Russian; Other _____

Address:_____ **Apartment No.:**_____

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

Home phone: (_____)_____
May we leave detailed messages at this number? (please circle) **YES** **NO**
Cell phone: (_____)_____
May we leave detailed messages at this number? (please circle) **YES** **NO**
Work phone: (_____)_____
May we leave detailed messages at this number? (please circle) **YES** **NO**

Email address: _____

Occupation:_____

Work Address:_____

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

Emergency Contact Person:_____

Relationship to you:_____ **Phone number:** (_____)_____

Referred by: (physician who referred you)_____

Office Address of the physician:_____

Phone number:(_____)_____

Name of Pharmacy:_____ **Phone number:** (_____)_____

Address:_____ **City:**(____)_____

I, the undersigned, hereby authorize my insurance compan(ies) to pay and assign directly to San Francisco Critical Care Medical Group, all medical and/or surgical benefit, if any. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize release of all information necessary to secure the payment of said benefits

Signed:_____ **Date:**_____