Salinas Family Practice Medical Group Inc.
1328 Natividad Road • Salinas, California 93906
(831) 757-8081

PATIENT INFORMATION RECORD

Please Print or Write Legibly & Hand Receptionist All Insurance Cards

HEAD OF HOUSEHOLD

LAST NAME	FIRST	MI	SEX	MARITAL STATUS S	M	W	D	SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE
MAILING ADDRESS IF DIFFERENT THAN ABOVE	CITY AND STATE	ZIP CODE

HOME PHONE	CELL PHONE	BUSINESS PHONE

EMPLOYER			OCCUPATION	
EMPLOYERS STREET ADDRESS			CITY AND STATE	ZIP CODE
SPOUSE'S NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	CELL NO.
SPOUSE'S EMPLOYER		OCCUPATION		BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS		CITY AND STATE		ZIP CODE

DEPENDENTS

LAST NAME (IF DIFFERENT)	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH
1.				
2.				
3.				
4.				
5.				

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
HUSBAND'S 1.	
WIFE'S 2.	
CHILDREN'S 3.	
OTHER 4.	

In Case of Emergency Contact:	NAME	RELATIONSHIP	PHONE #

ASSIGNMENT OF BENEFITS:
I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PROVIDER OF SERVICES ANY BENEFITS DUE ME FOR THOSE SERVICES. (FOR CONTRACTED INSURANCE ONLY)

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE:
I AUTHORIZED THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED _____ DATE _____