# Daniel Gaitan Personalized Healthcare

## REGISTRATION/UPDATE INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex ____M ____F Birthdate _____ SSN _____

Home Phone _____ Cell Phone _____ Email _____

In case of an emergency, who should we notify? _____

## PRIMARY INSURANCE INFORMATION

Insurance Name _____ I.D. Number _____

Insurance. Address _____ Group Number _____

Policy Holder _____ Relation to patient _____

Address/Phone (if different from patient) _____

Policy Holder Employer _____ Employer Phone _____

## SECONDARY INSURANCE INFORMATION

Insurance Name _____ I.D. Number _____

Insurance. Address _____ Group Number _____

Policy Holder _____ Relationship to patient _____

Address/Phone (if different from patient) _____

Policy Holder Employer _____ Employer Phone _____

## PHARMACY INFORMATION

Preferred Retail Pharmacy (name and phone #) _____

Preferred Mail Order Pharmacy (name and phone #) _____

I hereby assign all insurance benefits to WEST COUNTY MEDICAL SPECIALISTS, INC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred. I authorize said assignee to release all medical information necessary to secure the payment. I authorize the release of my medical information by or between any of my treating physicians involved in the administration of my healthcare and health benefits.

Signature _____ Date _____