Marina Diabetes Center ___________ ___________ PATIENT DATA SHEET

Referred by:______________________________

Primary Care Physician:____________________

PATIENT INFORMATION

Patient:____
(Last Name) (First Name) (Middle Initial)

Address:____
(Street) (City/State) (Zip Code)

Home Phone:__________________ Cell Phone:__________________ Work Phone:__________________

Date of Birth:_______________________ Sex: **__M __F** Marital Status: **__S __M __W __D __Separated**

SSN:______________ Patient's Employer:______________ Student Status: **__Full-time __Part-time __N/A**

Emergency Contact Person:__________________________________ Phone No:_____________________

Relationship to Patient:_______________________

Person Responsible for Balance (if different from patient, complete below):________________________

Responsible Party's Date of Birth:__________________

Responsible Party's Address:____

SSN:________________ Phone No.:__________________ Relationship to Patient:___________________

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance:___________________________________ Effective Date:______________________

Name of Insured:_______________________________________ Relationship to Patient:_______________

Insured's Date of Birth:____________ Insured's I.D. No:________________ Group No.:_______________

Insured's Home Address:_______________________________________ Phone No.:___________________

(If different from patient's address)

Insured Party Employed by:____________________________________ Phone No.:___________________

Employer's Address:____

Secondary Insurance:_________________________________ Effective Date:______________________

Name of Insured:_______________________________________ Relationship to Patient:_______________

Insured's Date of Birth:____________ Insured's I.D. No:________________ Group No.:_______________

Insured's Home Address:_______________________________________ Phone No.:___________________

(If different from patient's address)

Insured Party Employed by:____________________________________ Phone No.:___________________

Employer's Address:____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize Michael Robinson, MD, to administer / perform any medical and or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to Michael Robinson, MD, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners who are part of my health care team.

Signature of Responsible Party:___________________________________ **Date**:________________