ANDRES E GIRON, MD. FCCP
A MEDICAL CORPORATION
Pulmonary, Sleep and Internal Medicine
555 Marin St., Suite 110
Thousand Oaks, CA 91360
(805) 496-0440

ACCOUNT #_____

PATIENT NAME _ _____ _____

S.S. # _____ MARITAL STATUS: S – M – D – W SEX: F - M

ADDRESS_____

CITY _____ STATE _____ ZIP CODE_____

DATE OF BIRTH _____ AGE _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

OCCUPATION_____ RETIRED DATE _____ EMPLOYER_____

WORK ADDRESS _____ CITY _____ _ STATE ____ ZIP CODE_____

Who do we notify in an emergency? _____Phone _____

Who referred you to this Office? _____

Purpose of today's visit:_____

Do you want to receive lab results or any other kind of medical information via e-mail? YES ____ NO ____

E-Mail Address: _____

SPOUSE OR PARENT INFORMATION (INSURED):

NAME_____ DATE OF BIRTH_____

S.S.# _____OCCUPATION_____RETIRED DATE_____

EMPLOYER_____ WORK PHONE _____

WORK ADDRESS_____CITY_____ STATE ____ ZIP CODE_____

Please supply the front desk with your Insurance Card

I authorize the release of any medical record or other information necessary to process any claim either manually or electronically. I also authorize payment of medical benefits to the physician for services rendering to me. I am also aware that I am responsible for any co-payment fees at the time of my office visit.

Signature_____Date_____