JOHN B. COLLET JR., D.P.M.
1643 EAST MAIN STREET
VENTURA, CALIFORNIA 93001
PH. (805) 648 - 4105

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential)

DATE _____

PATIENT'S LAST NAME | FIRST NAME | MIDDLE | HOME PHONE

CURRENT STREET ADDRESS | CITY | STATE | ZIP | HOW LONG?

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS)

SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER | DATE OF BIRTH | AGE

EMPLOYED BY | EMPLOYER'S ADDRESS | SEX: ☐ MALE ☐ FEMALE

WORK PHONE | OCCUPATION | WHO REFERRED YOU TO OUR OFFICE?

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY | RELATIONSHIP | EMERGENCY PHONE

CURRENT STREET ADDRESS | CITY | STATE | ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

ADDRESS | GROUP OR LOCAL NUMBER

SUBSCRIBER'S NAME | SUBSCRIBER'S SOCIAL SECURITY NUMBER | SUBSCRIBER'S I.D. NUMBER

SUBSCRIBER'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER _____

SECONDARY INSURANCE COMPANY

ADDRESS | GROUP OR LOCAL NUMBER

SUBSCRIBER'S NAME | SUBSCRIBER'S SOCIAL SECURITY NUMBER | SUBSCRIBER'S I.D. NUMBER

SUBSCRIBER'S RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER _____

INSURANCE ASSIGNMENT

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

PATIENT'S SIGNATURE | DATE | DATE

INSURED'S SIGNATURE | DATE | DOCTOR'S SIGNATURE