Paul D. Corona, M.D.

PATIENT : **Last:** _____ **First:** _____ **MI:** _____

E-Mail : _____

Sex: M / F **DOB:** _____ **SSN:** - - **Marital Statu: M / S / D / W** _____

Address: _____ **City:** _____ **Zip Code :** _____

Phone # : _____ **Cell:** _____ **Work** _____

Driver's Lic. #: _____ **State:** _____ **Employer:** _____

Work Address: _____

To Whom May We Thank For Referring You? _____

Emergency contact : _____ **Relation:** _____ **Phone #:** _____

INSURANCE: **PRIMARY Insurance Co.:** _____ **ID#:** _____

Subscriber's Name: _____ **SSN:** - - **DOB:** _____

Relationship to Patient: **Self / Spouse / Parent / Other:** _____

SECONDARY Insurance Co.: _____ **ID#:** _____

Subscriber's Name: _____ **SSN:** - - **DOB:** _____

Relationship to Patient: **Self / Spouse / Parent / Other:** _____

AUTHORIZATION: I certify that the above information is true and I consent to any medical or surgical treatment rendered the patient under the general and special instructions of the physician.

Signature of patient (or parent if a minor) _____ **Date:** _____

Assignment of Insurance Benefits and Authorization to Release Information related to Medical Services provided

I, hereby, assign all benefits to Paul D. Corona MD, For services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made to Paul D. Corona MD, and authorize release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures.

I understand that I am responsible for all charges not covered by my insurance policy including, but not limited to: co-payments, deductibles, and non-covered services. A $15 fee will be assessed for any additional statements needed to collect my balance. I agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full responsibility for all charges if payment is not made on my behalf by my insurance company. I understand I will be responsible for all collection fees in the event that my account is not paid in full.

I have been informed and understand that I will be charged $60.00 for missing an appointment without giving 24-hrs notice

Signature: _____ **Date:** _____

Relationship to Patient: **Self / Spouse / Parent / Other:** _____

30011 Ivy Glenn Drive, Suite 101 • Laguna Niguel, CA 92677 • Phone: 949.481.0118 • Fax: 949.481.1162