



Joanne Vogel, M.D. Inc.  
 2301 Camino Ramon, Suite 200  
 San Ramon, California 94583  
 Phone: (925) 358-0305 Fax: (925) 358-0309

### Patient Information Form

PLEASE COMPLETE AND BRING TO YOUR FIRST APPOINTMENT

Legal Name:		Date:
Home Street Address:		City: Zip:
Home Phone #:		Other Phone #:
SS#:	DL#:	Date of Birth:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Name of Spouse:		Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:		
May we communicate with you via email, including normal test results?		<input type="checkbox"/> Yes <input type="checkbox"/> No
How did you learn about our practice? _____		
IN EMERGENCY NOTIFY: _____		Phone: _____
Relationship: _____		
<b>PATIENT'S EMPLOYMENT INFORMATION</b>		
Employers Name:		Occupation: <input type="checkbox"/> Not Employed
Employer's Address:		
Work Phone #:		Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
<b>INSURANCE INFORMATION</b>		
Primary Insurance:		Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS
Sponsor's Name:		Relationship to Patient:
I.D.#:		Group #:
Sponsor's Date of Birth:		
Sponsor's Employer:		Occupation:
Employer's Address:		
Employer's Phone #:		Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Secondary Insurance :		
Sponsor's Name:		Date of Birth: Relationship to Patient:
I.D.#:		Group #:
Sponsor's Employer:		Work Phone #:
Employer's Address:		
<b>Assignment of Benefits and Release of Information</b>		
I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits, to which I am entitled to, to Joanne Vogel, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as an original.		
Signature of Patient: _____		Date: _____

Please also review and sign the reverse side of this form.



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## OFFICE POLICIES

### NEW PATIENT PAPERWORK

Please complete the new patient paperwork prior to arriving to your appointment. When you do not do this, it delays your appointment and other patients after you.

### MISSED APPOINTMENTS

Our goal is to provide quality care to all of our patients. When an appointment is scheduled, a block of time in the doctors' schedule has been allotted to you, the patient, to allow adequate time to address all of your concern and provide medical treatment.

We reserve the right to charge a \$25.00 fee for all missed appointments that have not been cancelled 24 hours prior to the scheduled appointment time.

### LATE APPOINTMENTS

All patients that arrive more than 15 minutes late for a scheduled appointment may be rescheduled. This does not apply if prior arrangements have been made.

### DISABILITY AND OTHER FORMS

We realize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside of the contractual relationship between you and your insurance company. As a result, there will be a charge of \$20.00 for completing disability, workman's compensation and other forms. This needs to be paid prior to form completion.

All completed forms will be mailed to the insurance company, employer, you (the patient), or you will be called to pick up your form within 5 business days from the date the forms are received in our office. Every effort will be made to adhere to the response timeframe; however there may be exceptions. In the event of delay, the office will try to notify you.

### FINANCIAL RESPONSIBILITY

Your signature on this form acknowledges that you, the patient, agree to bear full financial responsibility for all services provided if:

1. You are determined not to be eligible for insurance coverage.
2. The services are not covered under your benefit plan.
3. The services have not been otherwise referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracting provider.

### RETURNED CHECKS

A fee of \$35.00 for checks returned to us for insufficient funds will be charged to your account. Future services will require payment by cash, money order or credit card for your payment obligations.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies.

Print Patient Name: \_\_\_\_\_

Patient or Legal Signature: \_\_\_\_\_

Date: \_\_\_\_\_