

**U.S. De Silva, MD**  
A Medical Corporation  
623 W Ave Q, Suite A  
Palmdale, CA 93551

**Patient Information**

Last Name: \_\_\_\_\_ First Name, MI: \_\_\_\_\_

Sex:  Male  Female

Social Security Number (optional): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Driver's License Number (optional): \_\_\_\_\_

Check appropriate box:  minor  single  married  divorced  widowed  
 separated

If patient is student, name of school/college: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Whom may we thank for referring you?: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone: \_\_\_\_\_

**Employer Information**

Patient or parent/guardian's employer: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work phone: \_\_\_\_\_

**Spouse's Information (if applicable)**

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Work phone: \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Driver's License Number (optional): \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Is this person currently a patient at this office?  Yes  No

**Insurance Information**

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Social Security Number (optional): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Insured's ID number: \_\_\_\_\_

Group number: \_\_\_\_\_

Insurance company address:: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Do you have any additional insurance?**  Yes  No

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Social Security Number (optional): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance company: \_\_\_\_\_ Insured's ID number: \_\_\_\_\_

Group number: \_\_\_\_\_

Insurance company address:: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please be aware that we will charge you \$25.00 for failed appointments and appointments not cancelled 24 hours prior to the scheduled appointment date.

**Assignment and Release**

I, the undersigned, \_\_\_\_\_, assign directly to U.S. De Silva Medical Inc all medical benefits, if any, otherwise payable to (blank) for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize U.S. De Silva Medical Inc to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions (including electronically submitted claims).

Signature of insured: \_\_\_\_\_ Date: \_\_\_\_\_