ROXBURY
SURGERY CENTER

450 NORTH ROXBURY DRIVE
SUITE 520
BEVERLY HILLS, CA 90210
P: (310) 246-4628
F: (310) 746-4663

PATIENT DEMOGRAPHICS

Patient's Name: Last, First, Middle Initial	S.S. #	Marital Status M I S I D I W I Sep	Birth Date
Street Address	City, State. Zip	Preferred Phone	
Patient's Employer	Occupation	Alternate Phone	
Employer's Address	City, State. Zip	OK To Leave Message ❑ YES ❑ NO	
Drug Allergies, If Any / Are you Diabetic?	Driver's License#	Email Address	
Spouse/Partner's Name: Last, First, Middle Initial	S.S. #	Birth Date	
Address (if Different from Patient)	City, State, Zip	Preferred Phone	
Spouse/Partner's Employer	Occupation	Alternate Phone	
Employer's Address	City, State, Zip	OK To Leave Message ❑ YES ❑ NO	

In Case of Emergency, Notify	Relationship	Home Phone
Referred By	Relationship	Home Phone
Insured Name	Effective Date	Certificate/ Policy# Group#
Name of Insurance Company	HMO ❑ YES ❑ NO	Subscriber #
Insurance Address		City, State, Zip
Referring Physician		Business Phone

AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS
RELEASE OF MEDICAL INFORMATION FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges incurred at the time of service or for any charges not covered by an approved contractual-provider insurance or insurance benefits. I am also responsible for any collection fees or legal costs incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered. I hereby authorize payment of benefits directly to Roxbury Surgery Center for the procedural, surgical and/or medical benefits if any, otherwise payable to me for their service.

HMO patients please be aware you are financially responsible for all unauthorized services.

I hereby authorize treatment by Roxbury Surgery Center.

Signature of Patient, Guarantor or Guardian	Date
Signature of Surgeons	Date