

Santa Maria Medical Group

Member Information

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____ Home # _____

Cell: _____ Name and Number in case of emergency: _____

Address: _____

Marital Status: Married Single Divorced Separated Widowed

Insurance Information

Insurance Name: _____ Group # _____

Name of Subscriber: _____ Date of Birth: _____

Social Security Number: _____ Subscriber ID: _____

Office Policy

Please be advised that by signing this policy you agree that all the information provided is accurate. Using another's information is illegal, if we suspect that the information provided is not valid, we have the right to discharge you from the practice.

It is the responsibility of the patient to know their insurances benefits and eligibility status. If insurance coverage has terminated, you are responsible for any balances. You should become familiar with your insurance's limitations and exclusions, deductibles, co-payments, copays, annual maximum, and etc. Full-time college students over the age of 18 need to provide the insurance with a full-time status letter every semester in order to be eligible for coverage.

Signature of Patient: _____ Date: _____

Signature of Guardian for a minor: _____