Susan M. Stuart M.D.
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La Jolla, CA 92037
(858) 623-6333 (858) 623-0204 (fax)

Please PRINT clearly with BLACK INK

Date of Appointment: ___________________ **Referring Physician or Primary Care Physician**_______________________

Patient's Legal Name: ____ **Name pt goes by:** _____________________

Address: ____ **Email Address:** _________________________

City: ____ **State:** ______________________ **Zip:** _______________

Home #: (___) ______________________ **Work#:** (___) ______________________ **Mobile #:** (___) __________________

Date of Birth: ______ / ______/ ______ **Age:** ___________ **Sex:** ____________ **SS#:** __________ - ________ - __________

Marital Status: ______________________ **Name of Spouse:** _____________________________ **# of Children:** _________

Patient's Occupation: ____ **Patient's Employer:** ________________________

Emergency

Contact : __________________________________ **Relationship:** _______________________**Phone#:** (___) ___________

E-mail Address or Cell Phone required for appointment confirmation____

How would you prefer to receive these confirmations? E-mail / Text Message

INSURANCE #1 POLICY HOLDER ☐ **Self** ☐**Spouse** ☐ **Parent** ☐**Other**

Insurance Policyholder's Name (If not patient): ____

Relationship to Patient: _______________________**Date of Birth:** ______/______/______ **SS#:** ______/_______/_______

Employer: ____

Address (If different from above): ____

City: ______________________ **State:** _________________**Zip:**________________ **Contact Ph#:** ______________

INSURANCE #2 POLICY HOLDER ☐ **Self** ☐**Spouse** ☐ **Parent** ☐**Other**

Insurance Policyholder's Name (If not patient): ____

Relationship to Patient: ________________________ **Date of Birth:** ______/______/______ **SS#:** ______/_______/_____

Employer: ____

Address (If different from above): ____

City: ______________________ **State:** _________________**Zip:** ____________**Contact Ph#:** __________________

Please read and sign below: I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-shares and deductibles will be collected. It is the patient's responsibility to notify this office if your insurance plan(s) require prior authorization before services are rendered**. If the patient is a minor form must be signed by a Legal Guardian or Responsible Party.**

IF PRIOR AUTHORIZATION IS REQUIRED AND NOT OBTAINED, YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.

Patient / Responsible Party Signature ____**Date**_____________