Genesee Medical Group

7830 Clairemont Mesa Blvd. Suite 100, San Diego, CA 92111

❑ Jeffrey H. Dysart, M.D.
❑ Craig M. Sclar, M.D.
❑ Donald Tecca, M.D.

PATIENT NAME_____
LAST FIRST MIDDLE

DATE OF BIRTH_____/_____/_____ SEX: M F SSN # _____-_____-_____
MON DAY YR

EMAIL ADDRESS _____@_____

MARITAL STATUS: S / M / D / SEP CA Driver's Lic./Expiration date_____

HOME ADDRESS_____
STREET

_____
CITY STATE ZIP

HOME PH_____ WORK PH_____CELL_____

OCCUPATION_____EMPLOYER_____

IN CASE OF EMERGENCY CALL

_____
NAME PHONE#

MINOR PATIENT (UNDER AGE 18)

PARENT#1 NAME_____
LAST FIRST MIDDLE

DATE OF BIRTH_____/_____/_____ SEX: M F SSN # _____-_____-_____
MON DAY YR

EMAIL ADDRESS _____@_____

MARITAL STATUS: S / M / D / SEP

HOME ADDRESS_____
STREET

_____
CITY STATE ZIP

HOME PH_____ WORK PH_____CELL_____

OCCUPATION_____EMPLOYER_____
DOES THIS PARENT HAVE CUSTODY ❑Y ❑N (REQUIRES DOCUMENTATION)

PARENT #2 NAME_____
LAST FIRST MIDDLE

DATE OF BIRTH_____/_____/_____ SEX: M F SSN # _____-_____-_____
MON DAY YR

EMAIL ADDRESS _____@_____

HOME ADDRESS_____
STREET

_____
CITY STATE ZIP

HM PH_____ WK PH_____CELL_____

OCCUPATION_____EMPLOYER_____

DOES THIS PARENT HAVE CUSTODY ❑Y ❑N (REQUIRES DOCUMENTATION)

BILLING INFORMATION

ALL PATIENTS - GUARANTOR INFORMATION (INSURED OR RESPONSIBLE PARTY)

❑ GUARANTOR SAME AS PATIENT

GUARANTOR
NAME_____
LAST FIRST MIDDLE

DATE OF BIRTH_____/_____/_____ SEX: M F S S N # _____-____-_____
MON DAY YR

BILLING ADDRESS_____
STREET

_____
CITY STATE ZIP

RELATION TO PATIENT_____

INSURANCE INFORMATION – COPY OF CARDS REQUIRED

Primary Insurance Company		ID Number		Group Number	
Insurance Address	City		State		Zip
Policy Holder					

Secondary Insurance Company		ID Number		Group Number	
Insurance Address	City		State		Zip
Policy Holder					

BILLING POLICIES:

I PERMIT PAYMENT DIRECTLY TO THE GROUP, OR THE PHYSICIAN SEEN ON DATE OF SERVICE, FOR ANY BENEFITS PAYABLE FOR THEIR SERVICES RENDERED.

I UNDERSTAND THAT Genesee Medical Group, AND ITS PROVIDERS, ACCEPT ASSIGNMENT OF MEDICARE. I HEREBY CONSENT TO BILLING FOR SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE, OR SHARE OF COST AS ASSIGNED BY MEDICARE.

MEDICAL RECORDS:
AUTHORIZATION IS HEREBY GRANTED FOR RELEASE OF ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

I UNDERSTAND THAT I WILL RECEIVE PERIODIC STATEMENTS REGARDLESS OF ANY CLAIMS PENDING. I UNDERSTAND THAT GENESEE MEDICAL GROUP CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING ON MY INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY MY INSURANCE COMPANY.

SIGNATURE: _____ DATE: _____