

**MICHELLE J. PLACE, MD., F.A.C.S**  
919 SAN RAMON VALLEY BLVD, SUITE 255  
DANVILLE, CA 94526

**(925) 837-1347**

**Patient Name:** \_\_\_\_\_  
Last First Middle  
Address: \_\_\_\_\_  
Street City State ZIP  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Other: \_\_\_\_\_  
Do you have any contact restrictions: \_\_\_\_\_  
Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ SS: \_\_\_\_\_  
Gender:  Female  Male Marital Status:  Single  Married  Other  
Who referred you to our office: \_\_\_\_\_

**Employment**

Name of employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Contact restrictions at work:  Yes  No  
Address: \_\_\_\_\_  
Street City State ZIP

**Emergency Contact Details**

Name of contact person: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

**Primary Health Insurance Company**

Name of Primary Insurance: \_\_\_\_\_ Ins Phone \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-pay amount: \_\_\_\_\_  
Name of primary insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Secondary Health Insurance**

Name of Secondary Insurance: \_\_\_\_\_ Ins Phone \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-pay amount: \_\_\_\_\_  
Name of secondary insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

I understand that office visit charges are payable on the day that services are rendered. I authorize Dr Place to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr Place and myself

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_