MICHELLE J. PLACE, MD., F.A.C.S
100 Park Place, Suite 240
San Ramon, CA 94583 **(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:**__________