Patient Profile

Sherman Oaks Family Medicine, Inc.
Donna Cashdan, D.O., F.A.A.F.P.

General Patient Information

Last Name	First Name	M.I.	SS No.

Address	Date of Birth	Phone	Home	Work	Cell	Other
			○	○	○	○
City State ZipCode	Sex ○ Male ○ Female		○	○	○	○
			○	○	○	○

Marital Status: ○ Single ○ Divorced ○ Married ○ Married

Ethnicity: ○ Asian ○ Black/African American ○ Hispanic/Latino ○ American Indian/Alaska Native ○ White ○ Hawaiian or Other Pacific Islander ○ Unknown

Emergency Contacts

	Name	Phone	Alternate Phone	Relation to Patient
1				
2				

Patient's Employment

○ Employed ○ Unemployed ○ Retired Student: ○ Part Time ○ Full Time School:

Employer Name	Employer Address		
Employer City	Employer State	Employer Zip Code	Employer Phone Number

Guarantor: (Who should receive patient's billing statement?) ☐ Same as patient? If not, fill in Guarantor info below.

Guarantor's Full Name	Relation to Patient	Guarantor's Employer

Guarantor's Address	Guarantor's Date of Birth	Guarantor's Phone Numbers	Home	Work	Cell	Other
	Sex ○ Male ○ Female					
		Social Security Number				

	Patient's Primary Insurance	Patient's Secondary Insurance
Insured Category	Same as patient / Same as Guarantor / Other	Same as patient / Same as Guarantor / Other
Insured's Name		
Insured's Carrier Name		
Insured's ID		
Insured's Group/Policy Number		
Insured's Date of Birth / Sex	○ Male ○ Female	○ Male ○ Female
Insured's Social Security Number		
Insured's Employer		
Insured's Relation to Patient		

Patient Referred by	Privacy Information Received Yes No	Date Received

Patient Referred by: CONSENT TO TREAT: I hereby consent to the administration and performance of all diagnostic procedures and treatments which, in the judgement of my physician may be considered necessary or advisable.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Sherman Oaks Family Medicine, Inc., and I am financially responsible for non-covered services. I also authorize Sherman Oaks Family Medicine Inc. to release any information required in claims processing.

Patient's Signature	Date Signed	
(If patient is a minor, parent's signature)	Name of person filling out this form	Relationship to Parent

FOR OFFICE USE ONLY
Date entered into computer
Employee Name
Medical Record #
Primary Care Physician