PRENTICE, MITRI & HIJAZIN NEUROLOGICAL ASSOCIATES

10916 DOWNEY AVE, DOWNEY, CA 90241

PHONE (562) 861-1988 FAX (562) 861- 5835

**INFORMACION DEL PACIENTE:**

APELLIDO:­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NOMBRE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I:\_\_\_\_\_\_

FECHA DE NACIMIENTO:­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EDAD:\_\_\_\_\_\_\_\_ GENERO:\_\_\_\_\_\_\_

# DE SEGURO SOCIAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOMICILIO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT:\_\_\_\_\_

CIUDAD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ESTADO: \_\_\_\_\_\_ CODIGO POSTAL:\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEFONO (PRIMARIO) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SECUNDARIO)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CORREO ELECTRONICO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACTO DE EMERGENCIA:**

TELEFONO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELACION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERIDO POR:**

APELLIDO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NOMBRE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOMICILIO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STE:\_\_\_\_\_\_\_\_ CIUDAD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ESTADO:\_\_\_\_\_\_\_\_\_CODIGO POSTAL:\_\_\_\_\_\_\_\_\_\_\_\_

TELEFONO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Financial Responsible Assignments of Benefits-Release of Information – Please Read**

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME: INCLUDING THE BALANCE REMANING AFTER PAYJENT OF POSSIBLE INSURANCE BENEFITS TO BE PAID TO PRENTICE, MITRI, AND HIJAZIN NEUROLOGICAL ASSOCIATES, RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

**Privacy Act – Please Read**

CONGRESS HAS PASSED A NEW LAW TO PROTECT THE PRIVACY OF ALL PATIENTS AS IT APPLIED TO THEIR MEDICAL INFORAMTION COLLECTED BY DOCTORS WHO CARE FOR THEM. IN ACCORDANCE WITH THIS LAW, WE ARE REQUIRED TO COLLECT YOUR SIGNATURES ON THE ACCOMPANYING FORMS, SO THAT WE MAY CONTINUE TO PROTECT YOUR PRIVACY AND AT THE SAME TIME SHARE THIS INFORMATION WITH SUCH ENTITIES, AS WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH THE BEST HEALTH.

**Firma del paciente (o padre si el paciente es menor de edad)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** FECHA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_