CAROL ELIAS, PH.D. **(909) 622-0148**
556 N. Diamond Bar Blvd., Ste. 103
Diamond Bar, CA. 91765

8608 Utica Ave., Ste. 213
Rancho Cucamonga, CA. 91730

PATIENT INFORMATION

Name (first, middle, last): _____
Address (street, city, state, zip): _____
Home Phone # _____ Work Phone # _____
Cell # _____ Relationship Status: _____
Sex: M or F Date of Birth: _____ Social Security # _____
Driver's License # _____ Primary Care Physician (name, address, ph. #): _____
_____
Employer (name & address): _____

RESPONSIBLE PARTY INFORMATION
(complete the following, if different from patient)

___self ___spouse ___parent ___other/relationship _____
Name (first, middle, last): _____ D.O.B. _____
Address (street, city, state, zip): _____
_____
Sex: M or F Home Phone # _____ Work Phone # _____
Social Security # _____ Driver's License # _____
Employer (name & address): _____
_____

INSURANCE INFORMATION

Primary Carrier (name, address, & ph. #): _____
_____
Subscriber: _____D.O.B._____
Member I.D.# _____ Group # _____
Secondary Carrier (name, address, & ph. #): _____
_____
Subscriber: _____D.O.B._____
Member I.D.# _____ Group # _____

Please provide a copy (both sides) of insurance card and a completed insurance form.
I understand that all appointments must be cancelled 24 hours in advance or I may be charged for the appointment. I also understand that if this account, due to nonpayment, must be turned over for collections, I understand that I will be responsible for costs. In this event, no disclosure of clinical material will be revealed. In the case of returned checks, there will be a $25 service charge.
I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature: _____ Date: _____