




Grace Medical Group of the Valley, Inc – Biographical Information Data Sheet

Please complete this form, sign and return it to the receptionist. Thank you!

(por favor complete firme la forma. Gracias.)

Patient Information

Last Name (Apellido)		First Name (Nombre)		Middle Name (Sengundo Nombre)
Current Address (Direccion)			Marital Status	
(City) (State) (9 Digit Zip Code)			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Minor <input type="checkbox"/> Other	
Date of Birth (Fecha De Nacimiento)		Gender		
mm / dd / yyyy		<input type="checkbox"/> Male (Hombre) <input type="checkbox"/> Female (Mujer)		
Primary Contact		Ethnicity		
<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone		(Country of Origin)		
Home Phone (Numero Del Telefono)		Language of Preference (If NOT English)		
()		Employer (Empleador)		
Cell Phone (Numero Del Telefono)		Work Phone (Empleador Telefono)		
()		()		
Email (e-mail)		 <p>Please provide a picture ID to the receptionist when submitting this form.</p>		
Race				
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black Hispanic or Latino <input type="checkbox"/> White Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White				

Emergency Contact

In case of an emergency, who should we contact? (En caso de una emergencia, a quien debemos de llamar?)

Name (Nombre)	Relationship (Relacion Con El Paciente)
Home Phone Number ()	Work Phone Number ()

Insurance Information (Informacion De Aseguranza)

Name or Insured (Nombre)		
Name of Insurance	Policy #	Group #

Authorization and Release (Autorizacion)

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the health care provider. I hereby authorize the health care provider to release any information acquired in the course of my examination or treatment. If insurance information is provided above, I (patient or guardian) am an eligible member as of this date of service of a health plan and a copy of the benefits card is included in this chart. Signature of responsible party below acknowledges full financial responsibility of services rendered to me if it is determined I am not eligible on the date of service in question or if service rendered is determined to be non-covered benefit under the plan provisions.

I hereby irrevocably authorize payment directly to the corporation/physician, benefits otherwise payable to me but not to exceed the corporation's physician's regular charge due as a result of this claim. I understand I am financially responsible to the corporation/physician for charges not covered.

Patient or Guardian Signature (Firma Del Paciente or Padres si es Minor)

Date (Fecha)