Orthopaedic Foot & Ankle Center, A Medical Group
Carol C., Frey, M.D.

1200 Rosecrans Ave., Manhattan Beach, CA 90266

Patient Information

Patient Name _____
Address _____
Street City State Zip

Home Phone # (_____) _____ Date of Birth ____/____/____ Age _____
Employer _____
Employer Address _____
Street City State Zip

Work Phone # (_____) _____ Occupation _____
Social Security # _____ Driver's License # _____

Responsible Party

Emergency Contact _____
Emergency Contact Employer _____
Address _____ _____
Street City State Zip

Work Phone # (_) _____ Relationship to Patient _____
Social Security # _____ Driver's License # _____

Insurance Information

#_____Medicare#_____Medi-Cal#_____CCS#_____
Private insurance
#_____Company_____Certificate#_____Group#_____
Address _____
Street City State Zip

Insured's Name _____ Insured's D.O.B. _____
Circle patient's relationship to insured: Self Child Spouse Other _____
#_____Company_____Certificate#_____Group#_____
Address _____
Street City State Zip

Insured's Name _____ Insured's D.O.B. _____
Circle patient's relationship to insured: Self Child Spouse Other _____

Patient Information

Injury Related to: □Work □Accident Date of Injury ___/___/___ Date of Last Work ___/___/___
Send Bills To: □Insurance □Attorney
Name _____ Phone # (_____) _____
Address _____
Street City State Zip

Employer _____ File# _____
Claims Adjuster _____ Phone # (_____) _____

Referring Physician

Referring Physician _____ Phone # (_____) _____
Address _____
Street City State Zip

Authorization: I hereby authorize the physician to furnish to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

X _____ _____
Signature Date