Location of appointment: **Dr. Ronald B. Moss** ronaldmossmd92024@gmail.com Tel:760-436-6404

My appointment is with Dr. Ronald B. Moss
Appointment Date:
Check in time:

Dr. Ronald B. Moss

PATIENT INFORMATION

LAST NAME:_____ MARRIED: YES_____ NO_____

FIRST NAME:_____ MALE_____ FEMALE_____

MIDDLE NAME:_____ OTHER FAMILY MEMBERS WHO ARE

DATE OF BIRTH:_____ PATIENTS:_____

ADDRESS **SPOUSE'S INFORMATION**

STREET OR PO BOX:_____ SPOUSE'S NAME:_____

CITY, STATE:_____ STREET OR PO BOX:_____

ZIP CODE:_____ CITY, STATE:_____

PHONE:_____ ZIP CODE:_____

OCCUPATION:_____ PHONE: (_____)_____

EMPLOYER:_____ DATE OF BIRTH:_____

BUSINESS PHONE:_____ OCCUPATION:_____

EMAIL ADDRESS:_____ EMPLOYER:_____

ADDITIONAL PHONE:_____ BUSINESS PHONE:_____

MEDICAL INSURANCE INFORMATION

FINANCIAL RESPONSIBILITY PARTY:_____

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY:_____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

SUBSCRIBER NAME:_____ SUBSCRIBER NAME:_____

SUBSCRIBER ID #:_____ SUBSCRIBER ID #_____

GROUP OR PLAN #:_____ GROUP OR PLAN#:_____

HOW WERE YOU REFERRED TO OUR OFFICE

REFERRED BY:_____

PRIMARY DOCTOR: (FIRST AND LAST NAME)_____ **PHONE:**_____

COMPLETE MAILING ADDRESS:_____
STREET **SUITE** **CITY** **STATE** **ZIP**

Name and complete address of any additional MD's to whom the report should be sent to:_____

FAMILY PHARMACY PHONE# (_____**)**_____

NAME OF PERSON AND PHONE NUMBER IN CASE OF AN EMERGENCY (not someone living in the same home address)

AUTHORIZATION TO RELEASE INFORMATION FOR SERVICES RENDERED BY DR. RONALD B. MOSS, MD & ASSIGNMENTS OF BENEFITS

I authorize the release of information of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked by me any time in writing. I also authorize Dr. Ronald B. Moss to apply for benefits on my behalf for the services rendered. I request that payment from my insurance company to be made directly to Dr. Ronald B. Moss, LLC. I certify that the information is correct. If the insurance information given is not in effect on the date of service. I will be financially responsible.

DATE:_____ **SIGNATURE:**_____

Front office demographic doc