Catalina Pointe
Arthritis & Rheumatology Specialists, PC

We are contracted with several of the local insurance carriers, which require appropriate referrals. OBTAINING THIS REFERRAL IS THE PATIENT'S RESPONSIBILTY. If seen without the necessary authorization and eligibility, you are responsible for any charges incurred.

PLEASE PRINT AND FILL OUT COMPLETELY

Patient Information

Name: _____

Local Street Address: _____ City: _____ State: _____ Zip: _____

Out of State Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Sex: Male __ Female __ Marital Status: M __ S __ W __ D __

Birthdate: _____ Name of Spouse/Parent: _____

In Case of Emergency Call: _____ Phone: _____ Relationship: _____

Address: _____

Work Information

Occupation: _____ Employer: _____

Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy

Pharmacy Name: _____ Location: _____ Ph: _____.

Insurance Information

Insurance card(s) will be photocopied, but the following information must be completed.

Primary Insurance	**Secondary Insurance**
Insurance Co. Name: _____	Insurance Co. Name: _____
Ins. Co. Address: _____	Ins. Co. Address: _____
Policy Holder Name: _____ DOB _____	Policy Holder Name: _____ DOB _____
Relationship to patient: _____	Relationship to patient: _____
Policy Holder's Employer: _____	Policy Holder's Employer: _____
Policy #: _____ Group # _____	Policy #: _____ Group # _____

Are you covered by a Senior HMO ☐ Yes ☐ No
Do you have Tricare for Life: ☐ Yes ☐ No
Are you covered by Medicare ☐ Yes ☐ No
Do you have any other insurance ☐ Yes ☐ No If yes: _____

Primary Care Physician: _____ PH: _____ Referring Doctor: _____

Assignment and Release: I hereby authorize Catalina Pointe Arthritis & Rheumatology Specialists PC, to release medical information required in the course of my examination or treatment to any physician(s) treating me and for insurance claim purposes.
I authorize payment of medical benefits to Catalina Pointe Arthritis & Rheumatology Specialists PC, for services rendered. I understand that I am responsible for all charges not covered by my medical insurance. In addition, I am responsible for any deductible, co-payments, and co-insurance amounts. I further understand that should my account be turned over to collections, I am responsible for all fees accrued by collection agencies, court costs, or attorney fees.

This may be released by fax.

SIGNATURE: _____ Date: _____