

**INFORMATION REQUIRED FOR CASE HISTORY FILE (Please Print)**

1.  Male  Female Primary Care Physician \_\_\_\_\_  
Referring Physician \_\_\_\_\_

Patient Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

2. Symptoms: \_\_\_\_\_

3. **Medical Coverage Information – Please Present Your Insurance Card**

Primary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  Male  Female

Subscriber's Employer \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  Male  Female

Subscriber's Employer \_\_\_\_\_

4. **Type of Injury:**  Work related injury  Automobile accident  Other accident/injury\*

Date of Injury \_\_\_\_\_ Claim# (if known) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Adjuster \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer when injured \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Required for Worker's Compensation only)

\*Briefly explain "Other" accident/injury \_\_\_\_\_

5. **Responsible Party for Patient under 18 Years of Age**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  Male  Female

Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
If different from above

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Please see reverse side



I HEREBY AUTHORIZE MY REFERRING PHYSICIAN TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO COMPLETE MY MEDICAL CARE.

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER OF SERVICES ITEMIZED ON SAID CLAIM.

I UNDERSTAND THAT FEES ARE SUBJECT TO CHANGE BASED ON ACTUAL EXAM(S) PERFORMED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES OR CHARGE BALANCES NOT PAID BY MY INSURANCE AND AGREE TO PAY THESE AMOUNTS.

I UNDERSTAND THAT IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO COLLECT AN UNPAID BALANCE DUE FOR MEDICAL SERVICES RENDERED, I AGREE TO PAY FOR REASONABLE ATTORNEY FEES OR OTHER SUCH COSTS AS THE COURT DETERMINES PROPER.

I HEREBY ACKNOWLEDGE THE RECEIPT OF A COPY OF THE RAS NOTICE OF PRIVACY PRACTICES.

INITIALS

PHOTO ID CHECKED \_\_\_\_\_  
STAFF INITIALS

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California.  
(800) 633-2322  
www.mbc.ca.gov

X \_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

DECLINING TO SIGN OR ALTERING THIS FORM WILL RESULT IN  
RAS BEING UNABLE TO PROVIDE SERVICES TO YOU.