

**Tustin Longevity Center**  
 13422 Newport Avenue, Suite L  
 Tustin, CA92780 Phone: 714-544-1521

**PATIENT INFORMATION FORM**

Today's Date:			
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**PATIENT INFORMATION**

Patient's Last Name		First	Middle			Marital Status		
				<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Sgl <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid		
				<input type="checkbox"/> Miss	<input type="checkbox"/> Ms.			
Is this your legal name?		If not, what is your legal name?		(Former Name)		Birth Date	Age	Sex
<input type="checkbox"/> Yes	<input type="checkbox"/> No							<input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home Phone No.		
						( )		
Driver's License		Email Address				Mobile Phone No.		
						( )		
Employer Address		Employer City, State, Zip				Work Phone No.		
						( )		
Referral information: Physician:			Other:	Test: <input type="checkbox"/>				

**INSURANCE INFORMATION**

Insured Name		Birth Date	Address (if different)		Home Phone No.	
					( )	
Occupation	Employer	Employer Address			Employer Phone No.	
					( )	
Subscriber's Name		Subscriber's Social Security #	Birth Date	Group #	Policy #	
Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of Primary Insurance		Subscriber's Name		Group #	Policy #	

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No.	Work Phone No.
			( )	( )

Address, City, State:

**Advance Directives:** : If you need information about advance directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will) please call the member services department of your health plan.

**Assignment of Benefits:**  
 I hereby assign my insurance benefits to be made directly to Dr. Ellithorpe and any assisting physicians for services rendered.

Name:	Date
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**Insurance Eligibility and Financial Agreement:**  
 I hereby attest that I am an eligible member of \_\_\_\_\_ insurance company and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company within 30 days.

Name:	Date
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**Release of Medical Records:**  
 I also hereby authorize \_\_\_\_\_ to release all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment or care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

Name:	Date
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X		
	PATIENT/GUARDIAN SIGNATURE	DATE