JAY L. JORDAN, M.D., INC.
8631 W. 3RD STREET, SUITE 445E
LOS ANGELES, CA 90048
310-854-5493

PATIENT NAME:_____ BIRTHDATE:_____ AGE____ SEX____

MAILING ADDRESS:_____CITY_____ STATE____ZIP_____

HOME TELEPHONE_____ CELL:_____ WORK:_____

SOCIAL SECURITY #_____ DRIVER'S LIC/STATE ID#_____

EMPLOYER:_____ TELEPHONE:_____

EMPLOYER'S ADDRESS_____CITY:_____ZIP_____

MARITAL STATUS: M__S__W_D__ SPOUSE NAME:_____EMPLOYED:___YES___NO
SPOUSE EMPLOYED BY:_____ ADDRESS:_____
CITY_____ STATE_____ ZIP_____TELEPHONE_____

EMERGENCY CONTACT:_____ TELEPHONE_____
ADDRESS:_____CITY_____STATE_____
REFERRED BY:_____ ADDRESS_____
CITY_____ STATE_____ ZIP_____ PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO_____ ADDRESS_____
CITY_____STATE_____ZIP_____ PHONE_____
INSURED_____ SS#_____ GROUP #_____
SECONDARY INSURANCE CO_____ADDRESS_____
CITY_____ STATE_____ZIP_____ PHONE_____
INSURED_____ SS#_____ GROUP #_____
ADDITIONAL INSURANCE CO._____ADDRESS_____
CITY_____ STATE_____ZIP_____ PHONE_____

RELEASE OF INFORMATION AND ASSIGNMENT

I hereby authorize and direct my insurance carrier to pay Jay L. Jordan, M.D., Inc., directly any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am uninsured, I understand I am fully responsible for all charges.

_____ _____
Signature of Patient or Personal Representative **Date**