

**SUSAN M. STUART, M.D.**

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**PATIENT INFORMATION**

(Please PRINT Clearly  
with BLACK Ink)

Date of Appointment: \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Patient's Legal Name \_\_\_\_\_ Name pt goes by: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#: ( ) \_\_\_\_\_ Work#: ( ) \_\_\_\_\_ Moblie#: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_ # of Children: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# : ( ) \_\_\_\_\_

**INSURANCE #1 POLICY HOLDER**  Self  Spouse  Parent  Other

**Insurance Policy Holder's Name (if not patient):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** (If different from above) \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Contact Ph#** \_\_\_\_\_

**INSURANCE #2 POLICY HOLDER**  Self  Spouse  Parent  Other

**Insurance Policy Holder's Name (if not patient):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** (If different from above) \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Contact Ph#** \_\_\_\_\_

**Please read and sign below: I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-shares and deductibles will be collected. It is the patient's responsibility to notify this office if your insurance plan(s) requires prior authorization before services are rendered.

**IF PRIOR AUTHORIZATION IS REQUIRED AND NOT OBTAINED, YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.**

**Patient / Responsible Party Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_