

# SONDRA J. ALTMAN, M.D.

120 La Casa Via Suite 104  
Walnut Creek, CA 94598

## WELCOME TO OUR OFFICE

*In order to serve you properly we will need the following information. (PLEASE PRINT) All information is strictly confidential.*

Patient's Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Marital Status: S M D Other  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_  
Home Ph.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Work Ph.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Cell Ph.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_   
(Check the box after each number if it is ok to leave a message on your recorder)  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Parent or Guardian's Name (If patient is under 18 years old): \_\_\_\_\_

\* Primary Insurance Company Name: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Employer Name: \_\_\_\_\_

\* Secondary Insurance Company Name: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_ - \_\_\_ - \_\_\_ Employer Name: \_\_\_\_\_

Do you authorize the release of your medical information to anyone other than the insurance carriers listed above?  
If yes, please list all here (specific MD names, your spouses name, etc.): \_\_\_\_\_

\_\_\_\_\_  
In case of an emergency,  
Name of Nearest Friend or Relative: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
If the patient is under 18 years old, can this person authorize treatment: \_\_\_ Yes \_\_\_ No \_\_\_ Initials

***I am aware that it is my responsibility, as the patient, to know my own insurance plan benefits. As well as the preferred lab for my insurance plan. I understand that it is not the responsibility of Dr. Altman or her staff to find out my insurance plan benefits. I agree that I am responsible for all charges, regardless of my insurance coverage. Such as; annual GYN exams, lab work done at a non-preferred lab, etc. \_\_\_ Initials***

***Annual GYN Exams: \_\_\_ Covered \_\_\_ Not Covered***

***My Preferred Lab is: \_\_\_ Muir Lab \_\_\_ Quest Diagnostics \_\_\_ West Coast Pathology***

***I HAVE BEEN GIVEN AN OPPORTUNITY TO READ DR. ALTMAN'S NOTICE OF PRIVACY PRACTICES (located on the reception window)***

Patient (or guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_