**ACCOUNT #**

# SAN DIEGO ARTHRITIS MEDICAL CLINIC
# Michael I. Keller, M.D., Inc.

**PLEASE PRINT** **DATE:** _____

## PATIENT INFORMATION

Patient Name: _____ SS#: _____ DL# _____

Birthdate: _____ Age: _____ Sex: ( ) Male ( ) Female Marital Status: M S D W SEP

Home Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Message Phone: _____

Employer Name: _____ Employer Address: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer Name: _____ Spouse's Employer Address: _____

Emergency Notification: _____
(Not residing in same household)

## PHYSICIAN INFORMATION

Referred by Name: _____ Address: _____

Physician Name: (Physician providing your general medical care) _____

Physician's Address: _____ City: _____ ST: _____ Zip: _____

## INSURANCE INFORMATION

Insured's Name: _____ SS#: _____ Birthdate: _____

Primary Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____ City: _____ ST: _____ Zip: _____

Effective Date: _____ GRP#: _____ ID#: _____

Secondary Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____ City: _____ ST: _____ Zip: _____

Effective Date: _____ GRP#: _____ ID#: _____

## AUTHORIZATION

I hereby authorize my physician to furnish information concerning my medical records to insurance companies, my attorney and other concerning / referring physicians.

Your Signature: _____ Date: _____

If the doctor is a provider of your insurance company, we will bill your primary insurance and collect appropriate deductibles and co-pays at the time of service. Co-insurance will be billed promptly after receipt of primary insurance, patient should remit upon receipt of the co-insurance. If patient has a secondary insurance, we will bill them as a courtesy to you. I hereby give authorization for payment of insurance benefits to be made directly to Michael I. Keller, M.D., Inc. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. There will be a service charge of $25.00 for all returned checks.

Your Signature: _____ Date: _____

# CLINICAL RESEARCH

Many patients find participating in clinical research very rewarding. Participating allows patients to learn more about their disorder and the alternative treatments available. Often treatment opportunity may provide better control of their problem and may help other people throughout the country with similar problems. Frequently there is reimbursement for travel and time available to the participant. Many patients have a sense of accomplishment and great purpose.

**Have you ever participated in clinical research?**. . . . . ( ) Yes ( ) No

**Would you like to learn more about our research?** . . . ( ) Yes ( ) No

**May we contact you regarding clinical research?**. . . . ( ) Yes ( ) No

| | | | |
|---|---|---|---|
| ( ) Arthritis | ( ) Women's Health Problems | ( ) Mental Problems | ( ) Anxiety |
| ( ) Rheumatoid Arthritis | ( ) High Blood Pressure | ( ) Alzheimer's Disease | ( ) Neurological |
| ( ) Osteoarthritis | ( ) Elevated Cholesterol | ( ) Immune Disorder | ( ) Parkinson's |
| ( ) Osteoporosis | ( ) Weight Loss | ( ) Systemic Lupus | ( ) Other: |
| ( ) Chronic Pain | ( ) Smoking Cessation | ( ) Sjogrens Syndrome | ( ) Other: |
| ( ) Sleep Disorder | ( ) Stomach Problems | ( ) Depression | ( ) Other: |

**Do you have family that may have an interest?**. . . . . ( ) Yes ( ) No