

**RICHARD D. GRUTZMACHER, M.D.  
RICHARD A. LEWIS, M.D.  
PATRICIA B. SIERRA, M.D.**

TODAY'S DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ EXT: \_\_\_\_\_ CELL: \_\_\_\_\_

BEST PHONE TO REACH YOU: \_\_\_\_\_ EMAIL: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SS#: \_\_\_\_\_ SEX: M F

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: S D M W SPOUSE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR PRACTICE? Please check all that apply and give names where appropriate:**

FRIEND		RADIO	
DOCTOR		TV	
INTERNET		SACRAMENTO BEE	
PRACTICE DVD		SACRAMENTO MAGAZINE	
YELLOW PAGES		OTHER	

**INSURANCE INFORMATION:** PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST AT THE TIME OF REGISTRATION FOR COPYING. TELL HER WHO THE PRIMARY INSURANCE CARRIER IS. THANK YOU.

PRIMARY INSURANCE: \_\_\_\_\_ Subscriber \_\_\_\_\_

Relationship \_\_\_\_\_ SSN \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F

SECONDARY INSURANCE: \_\_\_\_\_ Subscriber \_\_\_\_\_

Relationship \_\_\_\_\_ SSN \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

IF YOU ARE INSURED BY AN INSURANCE COMPANY THAT REQUIRES A REFERRAL FROM YOUR PRIMARY PHYSICIAN, IT IS **YOUR** RESPONSIBILITY TO PROVIDE US WITH THE INITIAL REFERRAL AT THE TIME OF YOUR VISIT OR YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED. PLEASE PRESENT MEDI-CAL CARD AT THE TIME OF PATIENT REGISTRATION FOR THE CURRENT MONTH OF SERVICE. **INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF REGISTRATION.**

**PLEASE COMPLETE THE REVERSE SIDE ALSO. THANK YOU.**

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO GRUTZMACHER & LEWIS, A MEDICAL CORPORATION, ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE THE DOCTORS TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_

**FOR OUR PATIENTS WITH MEDICARE**

***PLEASE READ AND SIGN THE FOLLOWING...***

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO GRUTZMACHER & LEWIS, A MEDICAL CORPORATION, FOR ANY SERVICES FURNISHED ME BY THOSE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE *HEALTH CARE FINANCING ADMINISTRATION* AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE *HCFA 1500* FORM OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

IN MEDICARE ASSIGNED CASES, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES, SUCH AS A REFRACTION. CO-INSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

PLEASE ALSO BE SURE TO **FILL OUT** AND **SIGN** YOUR  
**MEDICAL HISTORY QUESTIONNAIRE & PRIVACY RULE LETTER**  
AND GIVE TO THE RECEPTIONIST WHEN FINISHED

**PLEASE COMPLETE THE REVERSE SIDE ALSO. THANK YOU.**