



**SHASTA CRITICAL CARE**  
 Specialists  
 180 Northpoint Drive  
 Redding, CA 96003  
 530-232-3000

*Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be strictly confidential. (PLEASE PRINT)*

Patient's Name \_\_\_\_\_ What do you wish to be called? \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ M/F \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_ Marital Status S M O

Occupation \_\_\_\_\_ Business Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Do you have Medicare? Yes No If yes, ID # \_\_\_\_\_

Do you have Medi-Cal? Yes No If yes, ID # \_\_\_\_\_

Do you have private medical insurance? Yes No

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Address \_\_\_\_\_ Address \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer Address \_\_\_\_\_ Address \_\_\_\_\_

Person financially responsible for this account: Self Other

If other, Name \_\_\_\_\_ Address \_\_\_\_\_

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

Nearest friend or relative not residing with you? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

\*I authorize this office to receive and to release information necessary to the named insurance company (or companies) to expedite insurance payment, and to keep my signature on file for billing purposes. I understand that I am responsible for all charges (including handling fees for late payments), regardless of insurance coverage (unless the physician is contracted with my insurance company including Medicare), for a covered service while my policy is in force. I agree to be responsible for payment when any necessary insurance authorization has not been obtained. I agree to pay for services or supplies that Medicare or any other insurance carrier may deem to be "medically unnecessary" or are otherwise not covered services by my insurance carrier(s).

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_