TERRY L. FRANKLIN, M.D.

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Monterey, CA 93940
P: 831-647-3190 F: 831-373-1007

Patient Name: ____
(Last) (First) (M.I.)

Date of Birth: ______________________ Age: ____________ Sex: Male/Female

SSN: __________________ Marital Status: S M D W Email Address: ___________________________

Race: □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander
□ Black or African American □ White □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Language: □ English □ Spanish □ Japanese □ Chinese □ Korean □ French □ German □ Russian □ Other

Home Address: ____

City, State, Zip: ____

Home Number: ____________________________ Mobile Number: __________________________________

Employer/Occupation: __________________________ Employer Work #: _________________________________

Emergency Contact: ____
(Name) (Number) (Relationship)

Preferred Pharmacy: ____

If Patient is a minor:
Parent/Guarantor: ____
(Last) (First) (M.I.)

Date of Birth: _____________________________________ SSN: ___________________________________

Home Address: ____

City, State, Zip: ____

__________ (Initials) ASSIGNMENT OF INSURANCE BENEFITS: If the patient is entitled to medical benefits of any type arising out of a contract with a health insurance company, these benefits are hereby assigned to this office for application on the patients bill.

__________ (Initials) RELEASE OF INFORMATION: This office may disclose the patients record for this visit, to those health insurance companies responsible for payment of all or part of the office visit.

__________ (Initials) FINANCIAL AGREEMENT: I agree to pay all portions of this account, which are not covered by insurance or other sources of payment. This office will bill most insurance and will keep me informed of all insurance or other sources of payments and Balances due from me.

__________ (Initials) RECIPT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT SIGNATURE: ____ Date: ________________________