Jon G McLennan, MD, Inc
760.771.4900 Fax 760.771.4906
Billing (760) 360.9846 Billing Fax (760) 360.8643

# PATIENT INFORMTION

Name: ____________________________________________ Date: ____________________

Address: __________________________________________

City & Zip: ________________________________________ Referred By: ________________________

Phone: ____________________________________________ Phone: ____________________________

Cell: ______________________________________________

Email: _____________________________________________

Mailing Address (if different): __________________________ Primary Insurance: ____________________

__________________________________________________ Office Coverage: YES_____ NO ________

__________________________________________________ Member ID No: ______________________

Date of Birth: _______________________________________ Group No: ____________ Cov Code: _____

Drivers Lic State & No: _______________________________ Subscriber: __________________________

Gender: M / F SS #: ______________________________ Secondary Insurance: __________________

Race: ___________________Ethnicity: __________________ Office Coverage: YES_____ NO _____

Language: ____________________ Member ID No: ______________________

Employer: __________________________________________ Group No: ____________ Cov Code: _____

Address: ___________________________________________ Subscriber: __________________________

Occupation: _________________________________________

Business Phone: _____________________________________ Emergency Contact: ___________________

Spouse or Relative: ___________________________________ Relation ____________________________

Employer: ___________________________________________ Phone: ______________________________

Business Phone: ______________________________________

If someone other than patient is responsible for payment, please complete:

Name: ____________________ Address: __________________________ Phone: ______________

Employer & Address: _________________________________________________________________

I hereby authorize Dr. McLennan to furnish to the above insurance company(s) all information which said insurance company(s) may request.

I hereby assign to Dr. McLennan all money to which I am entitled for medical and/or surgical expense relative to the service rendered by her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above insurance company(s) over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court costs and reasonable legal fees should this be required.

__________________________________________ __________________________________________

Insured or Guardian Signature Date Patient Signature Date