

# MAKE YOU WELL

## Urgent Care + Family Practice

23365 Hawthorne Blvd. STE 104  
Torrance Blvd, CA 90505  
Phone: (424) 242-4060 Fax: (424) 567-8195

### Patient Demographic Form

#### Patient information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
SSN #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F  
Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Race (optional): \_\_\_\_\_ Language: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Marital Status:  S  M  D  W Employer: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact Phone #: (\_\_\_\_) \_\_\_\_\_  
How did you hear about us? Yelp / Google / ZocDoc / Drive By / Word of Mouth / Other \_\_\_\_\_

#### Insurance Policy Holder Information: Please provide insurance cards

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN #: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt: \_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insured's ID#: \_\_\_\_\_  
Policy Group ID #: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Insurance Plan Name/ Program: \_\_\_\_\_ Policy Holders Relationship: \_\_\_\_\_

#### Primary Care Provider & Pharmacy Information:

Primary Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

Please read and sign the following agreement so that we may proceed with your care and treatment at Make You Well.

I hereby authorize my insurance benefits to be paid directly to Make You Well. I understand and am responsible for all charges including my added costs incurred due to an effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to the insurance company.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO MEDICAL CARE:** The undersigned hereby consents to the procedure that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services, or other services rendered under general and special instructions of my health care provider.

**FINANCIAL AGREEMENT:** The undersigned, whether signed as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates of Make You Well. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

**ASSIGNMENT OF BENEFITS:** The undersigned, whether signed as a patient or representative of the patient, authorizes direct payment to Make You Well of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered to us, including emergency services, if any. Health care coverage benefit include Medicare, PPO, EPO, POS, HMO, other government issued health care benefits, as well as coverage under Workers' Compensation, automobile, life/accident, and disability insurance plans, The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

**WAIVER OF OUTSIDE LABORATORY AND RADIOLOGIST:** The undersigned, whether signed as a patient or representative of the patient understand that Make You Well may send lab specimens to an outside laboratory or send X-Rays taken by Make You Well to an outside Radiologist for reading. The undersigned, whether the patient or representative of the patient, understands that they may incur additional charges as a result and understands that Make You Well is not responsible for payment to those laboratories and radiologist.

**RELEASE OF MEDICAL INFORMATION:** The undersigned, whether signed as a patient or representative of the patient, authorizes Make You Well to release the medical records covering my son/ daughter/ self to any physician, hospital, or agency involved in the care of the patient listed.

**WAIVER OF ON SITE PRESCRIPTION PROGRAM (OPTIONAL):** The undersigned, whether signed as a patient or representative of the patient, has an option to have your prescription purchased from Make You Well. We do not participate in prescription insurance program, and will not refund any prescription for any reason.

**NOTICE TO CONSUMERS:** Medical doctors are licensed and regulated by the Medical Board of California (800) 633 – 2322. [www.mbc.ca.gov](http://www.mbc.ca.gov)

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, AND ACCEPTS, AND AGREES TO ABIDE BY ITS TERMS.

SIGNATURE OF PATIENT/ GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_\_

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE:

SIGNATURE (Financial Responsible Party): \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date: \_\_\_\_\_