

PETER WEBB, MD
50 S. SAN MATEO DRIVE, SUITE 350
SAN MATEO CA 94401

PATIENT INFORMATION
(PLEASE PRINT)

NAME _____ DATE _____

AGE _____ DATE OF BIRTH _____ SOC.SEC.# _____

ADDRESS _____ MALE _____ FEMALE _____

CITY & STATE _____ ZIP _____ MARRIED _____ SINGLE _____

HOME PHONE _____ EMAIL _____

EMPLOYER _____ WORK PHONE _____

PARENT/SPOUSE'S NAME _____

PARENT/SPOUSE'S EMPLOYER _____ WORK PHONE _____

WHO REFERRED YOU TO OUR OFFICE? _____

PRIMARY PHYSICIAN _____

IN CASE OF EMERGENCY CONTACT _____

PHONE _____ RELATIONSHIP _____

MEDICATION ALLERGIES _____

LIST ALL MEDICATIONS TAKEN IN THE LAST MONTH _____

INSURANCE INFORMATION
(PLEASE PRESENT CARD SO WE CAN COPY)

INSURANCE _____ ID# _____

SUBSCRIBER: SELF _____ SPOUSE _____ GROUP # _____

MOM _____ DAD _____

PERSON LEGALLY RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT):

NAME _____ PHONE _____

ADDRESS _____

AUTHORIZATION AND SIGNATURE
(READ, SIGN AND DATE)

I agree to pay all charges for treatment promptly regardless of delays in insurance payment or denial of coverage. I authorize release of information to insurance companies and payment of insurance benefits to Dr. Webb. A copy of Notice of Privacy Practices as been made available to me.

Signature _____ Date _____