uci medical affiliates

Patient Information

Please Print

Patient Demographics

Legal First Name | Legal Last Name | Suffix | Preferred First Name

Permanent Address | Apt. # | City | State | Zip

Phone # | Social Security # | Gender

Birth Date | Language | Marital Status | Email

Local or Alternate Address | Alternate Phone # | Today's Date

Have you been treated at any Doctors Care before? ☐ Yes ☐ No

Emergency Contact Information

Contact Name | Contact Phone #

Contact Address | Apt. # | City | State | Zip

Relationship to Contact

Name of a Relative Not Residing With You | Relative's Phone #

Patient Employment Information

Employment Status | Employer

Address | City | State | Zip

Occupation | Employment Contact | Phone # | Fax

Responsible Party's Information

Responsible Party's Legal Name | Social Security #

Responsible Party's Address | Apt. # | City | State | Zip Code

Medical Insurance Information

Please present your Insurance Card and ID with this form.

PSR Notes:

Policy Holder's Legal Name | Policy Holder's Social Security #

Policy Holder's Address | Apt. # | City | State | Zip

Policy Holder's Phone # | Relationship to Policy Holder | Policy Holder's Birth Date | Gender | Policy Holder's Employer

How did you hear about us? ☐Radio ☐Friend ☐Referral ☐Phone Book ☐Internet ☐Sign ☐Other