

**Mona I. Sarbu, MD**  
**Jon E. Ferguson, DO**  
Nephrology/Internal Medicine  
3011 Ceres Avenue, Suite 100  
Chico, CA 95973

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First MI Month Day Year

Address: \_\_\_\_\_  
Street (Apt#) City/State Zip

Mailing Address: \_\_\_\_\_  
(If different than above)

Sex: F \_\_\_ M \_\_\_ Marital Status: M \_\_\_ W \_\_\_ S \_\_\_ SSN#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home#: (\_\_\_\_) \_\_\_\_\_ Wk#: (\_\_\_\_) \_\_\_\_\_ Driver's Lic#: \_\_\_\_\_

Employer/Responsible Party: \_\_\_\_\_ Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Group#: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Cardholder Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Relation: \_\_\_\_\_

**IN CASE OF AN EMERGENCY:** Please list someone you are not currently residing with.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

**Consent For Treatment:** *I hereby agree to performance of such treatment that is, in the opinion of the attending physician, deemed necessary to the patient named above.*

**Release of Information:** *I hereby authorize Dr. Sarbu/Dr. Ferguson to release medical information to the insurance company covering the patient named above.*

**Assignment of Benefits:** *I hereby sign all my medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans, to Dr. Sarbu/Dr.Ferguson.*

**Statement of Financial Obligation:** *I understand that I am financially responsible to Dr. Sarbu/Dr.Ferguson for all charges incurred and that, unless other arrangements have been made, payment is due in full at the time of service.*

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date