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