630 S. Raymond Ave, Suite 340.
Pasadena, CA 91105
Phone (626) 583-0026
Fax (626) 584-6166
Email: ECAOffice@ECAMDINC.com
Website: www.ECAMDINC.com

PATIENT INFORMATION - PLEASE PRINT

Full legal name (First)	(Middle)	(last)		Name normally use (nickname)	
Address (Number & Apt)	(Street)	(City)	State	(Zip Code)	
Home Phone ( )	Can we leave a detailed message? Circle one: Y N	Cell/ Mobile Phone ( )		E-mail Address	
Date of Birth (Mo/Da/Yr) Age:	Sex (Circle) Male Female	Marital Status (Circle) M S W D	Social Security No.		Driver License No.
Employer Name and Address	City	State	Zip		Ethnicity
Work Phone ( )	Can we call you at work with test results? Circle One Yes No		Occupation		Race

SPOUSE OR PARENT INFORMATION

Name (First)	(Middle)	(Last)		Home Phone ( )
Address (**If Different Than Above**)	Street)	(City)	State	(Zip Code)
Date Of Birth (Mo/Day/Yr)	Social Security No.	Occupation		Work Phone
Employer Name and Address:		City	State	Zip Code

INSURANCE INFORMATION

Primary Insurance : Medicare Medical PPO Are you the Subscriber: Yes No

Insurance Name:	Medicare Number:	Group Number	Policy Number
Insurance Claim Address:		Insurance Phone Number:	

Secondary Insurance: Medicare Medical PPO Are You the Subscriber: Yes No

Insurance Name:	Medicare Number:	Group Number:	Policy Number:
Insurance Claim Address:		Insurance Phone Number:	

CASH PAY

EMERGENCY AND OTHER INFORMATION

Person to Notify in case of Emergency :			Phone Number:
Address (Number and Street)	City	State	Zip Code
Other Doctors you See?			
How Did You Hear About Us ?		Pharmacy Name and Phone Number :	

PLEASE SIGN AND RETURN

Financial Agreement: I Understand that I am responsible for all charges wheter or not they are cover by insurance. In the event of default, I agree to pay all cost of collection and attorney fees.

Assignment of Benefits: I hereby give lifetime authorization for payment to be made directly to ELISA C. ALVARADO, M.D. and any assisting Physicians, for services render. I hereby authorize this Healthcare Provider to release all information necessary to secure payment of benefit.

Our Notice Of Privacy Practice: Advises how we may use and disclose protected health information about you. Our current notice is available in our office lobby or on request. I agree to use and disclosure of my information for purposes of treatment, payment and practice operations.

Signature: ______________________ **Date:** ____________