Main Street Medical
Pamela Carrington-Tribble, D.O.
799 Main Street, Suite D, Half Moon Bay, CA 94019 • (650) 726-1200

Fill out all sections completely. Include your full legal name as printed on your insurance card.

PERSONAL INFORMATION

Who is responsible for patient? (circle) Self Parent Other _____

Legal name: _____
Last First Middle

Mailing Address: _____
Street Apt. City State ZIP Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Social Security Number: _____ DL Number: _____ State: _____

Date of Birth: ___/___/____ E-mail address: _____

Parent's Names (if under 18): _____ Spouse's Name: _____

Emergency Contact Name: _____

Phone number: _____ Relationship: _____

Sex: ◯ M ◯ F Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Partnered

Race: ◯ White ◯ African-American ◯ Hispanic ◯ Asian ◯ Other: _____

Preferred Language: _____ Living Will/Advance Directive: ◯ Y ◯ N

EMPLOYMENT INFORMATION

Employment Status: ◯ Full-time ◯ Part-time ◯ Retired ◯ Not employed ◯ Student ◯ Other: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

INSURANCE INFORMATION

Policyholder Name (if other than patient): _____

Date of birth: ___/____/____ Relationship to patient: _____

Primary insurance carrier:_____ Address: _____

Policy No.:_____ Group Number: _____

Secondary insurance carrier: _____ Address: _____

Policy No.:_____ Group Number: _____

Authorization for Treatment, Release of Medical Information and Assignment of Benefits

I authorize Main Street Medical to apply for benefits on my behalf for services rendered by Main Street Medical. I request payment from my insurance company be made directly to Main Street Medical. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

It is understood and agreed that I will reimburse Main Street Medical for the cost of any and all copayments, coinsurance, deductibles, non-covered services, excluded services, denials due to pre-existing conditions, denials due to elective services and any other costs not reimbursed in full by my insurance carrier upon receipt of an account statement.

PATIENT SIGNATURE: _____ DATE: ____/____/_____