

CAL. LIC.# G073592  
TAX ID# 77-0345563  
PROVIDER# F 39099

**TERENCE J. DELANEY, M.D.**  
**ORTHOPAEDIC SURGERY / ARTHRITIS SURGERY**  
14911 NATIONAL AVE STE 3  
LOS GATOS, CALIFORNIA 95032

TELEPHONE (408) 402-5742  
FAX (408) 358-2089

**AS A COURTESY THIS OFFICE WILL BILL YOUR PRIMARY INSURANCE COMPANY**

## PATIENT INFORMATION FOR MEDICAL RECORDS

PLEASE PRINT

PATIENTS NAME \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Last) (First) (M.I.)

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PH. # (\_\_\_\_\_) \_\_\_\_\_ CELL PH.# (\_\_\_\_\_) \_\_\_\_\_ WORK PH. # (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ BIRTHDATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ mm/dd/yyyy AGE: \_\_\_\_\_ GENDER:  M  F

MARITAL STATUS:  Single  Married  Divorced  Legally Separated  Widowed

NAME OF SPOUSE OR PARENT \_\_\_\_\_ PHONE # (\_\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # (\_\_\_\_\_) \_\_\_\_\_

DATE OF INJURY \_\_\_\_ / \_\_\_\_ / \_\_\_\_ PATIENT REFERRED BY \_\_\_\_\_

### **MEDICAL INSURANCE INFORMATION** (PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST TO COPY)

SUBSCRIBER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## Copy of Insurance Card

Primary Medical Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Secondary Medical Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

**PLEASE REMEMBER: Payment is your obligation regardless of insurance or other third party involvement.**

ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to the undersign physician. I am financially responsible for non-covered services. I also authorize the physician to release to my insurance carriers, any information required to process this claim.

SIGNED: X \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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(Patient/Parent, if Minor)