REGISTRATION / UPDATE

OBSTETRICS & GYNECOLOGY

Tillai Kannappan, M.D.

Gregory R. Klis, M.D.

James M. Tsai, M.D.

Noel G. Del Mundo, M.D.

Jacqueline Williams-Olango, M.D.

Luis Lopez, M.D.

Sauhang Patel, M.D.

PHYSICIAN ASSISTANT

Rhonda Colvin, PA-C

Anna Nazaryan, PA-C

Kristin Chisum, PA-C

NURSE PRACTITIONER

Toni-Ann McEnroe, OB/GYN NP-C

Patient Information

Date:_____ Doctor:_____ Primary Care Doctor: _____

Full Name: _____ Previous Name Used: _____
Last First M.I.

Mailing Address:_____ Home Phone: _____

City/State: _____ Zip: _____ Alternate Phone#: _____

Race: _____ Religion: _____ Marital Status: S M D W

Birthdate: _____ Age: _____ Soc. Sec. #: _____ Driver Lic #: _____

Email:_____

If Minor: (Ask for Disclosure Information)

Parent / Guardian Name: _____ Date of Birth: _____

Employer Information

Employer: _____ Occupation: _____ Phone: _____

Address: _____ Hours can be reached: _____

If we have to contact you by phone, how shall we identify ourselves: SDMG Dr's Office Other

Best phone number to reach you: _____

Spouse Name: _____ Date of Birth: _____ Soc. Sec#: _____

Spouse Employer: _____ Work #: _____ Occupation: _____

Phone #: _____ Alternative #: _____ Cell #: _____

Insurance Information

Primary Ins.: _____ Group/Plan#: _____ Policy / ID# _____

Ins. Address: _____ Eff. Date: _____

Policyholder's Full Name: _____ DOB: _____
Last First M.I.

Secondary Ins.: _____ Group/Plan#: _____ Policy / ID# _____

Ins. Address: _____ Eff. Date: _____

Policyholder's Full Name: _____ DOB: _____
Last First M.I.

Contact Info

In Case of Emergency, Call: _____ Relationship: _____

Phone #: _____ Alternative #: _____

Financial Agreement & Release of Information

I agree to pay all fees and charges for treatment rendered on behalf of myself and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. I understand that co-payments and deductibles, which have not been satisfied, are my responsibility and are required at the time of the visit, and if I am unprepared to pay, my visit will be reappointed. I also understand that I will be charged and billed for any appointment not kept without a minimum of twenty-four hours prior notification to the office. I fully understand that if services are provided to me and/or members of my family, which are deemed to be not covered by my health plan, that I am responsible for payment in full for those services. My signature, below, constitutes agreement to the aforementioned and agreement to pay for such services.

Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. If it is necessary to assign my account to a collection agency and/or attorney to collect and unpaid balance for services previously rendered to myself or my family member, I agree to pay for all collection agency and all attorney fees and costs.

The above information is for the purposed of obtaining credit and is warranted to be true. I authorize San Dimas Medical Group, Inc., to verify employment, insurance eligibility and benefits. I authorize assignment of my insurance payment to San Dimas Medical Group, Inc. and hereby authorize my Physician to release any information acquired in the course of my examination or treatment to my insurance company as needed.

_____ _____

Signature of Patient or Legal Representative Date

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