Redlands Family Practice
A PrimeCare Provider

Manuel A Cantun, MD
Henry M Chai, MD
Alexander Terrazas, MD
Maria Elena Terrazas, PA-C

Patient Information

Last Name ☐ Mr ☐ Mrs ☐ Ms	First Name	Initial	Date of Birth
Address	City	Zip	Home Phone
Driver's License #	Social Security #	Age	Cell Phone
Place of Employment			
Business Address	City	Zip	Work Phone
Name of Person we may contact in the event of an emergency			Phone #
Spouse's Name / Parents Name (if a minor)		Relationship	

Name of Primary Insurance Coverage	Secondary of Supplemental Insurance Coverage
Subscriber ID#	Subscriber ID#
Group #	Group#
Subscriber Name:	Subscriber Name
Subscribers Employer	Subscribers Employer

Please provide copies of your insurance cards so we can make copies for our records

I request that payment of authorized Medicare or other insurance benefits to be paid on my behalf to Redlands Family Practice, Inc., for any services furnished to me by this physician/supplier. I authorize any holder of medical information and its agents to provide any information needed to determine these benefits payable for related services. I understand that I am financially responsible for all charges not covered by the insurance coverage and this authorization (A copy of this assignment as valid as the original).

I authorize Redlands Family Practice and it representatives to access my prescription history available through my prescription benefit plan.

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Signature of Patient (or responsible party) **Date**

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Print Name

Admin Use Only: Scanned ________________