Eric Michael Munro MD Inc
Internal Medicine
3500 Lomita Blvd., Suite 100
Torrance, CA 90505
Ph: 310-784-0300 Fax: 310-784-0303

Patient Information

Last name: _____ First name: _____ M.I.: _____ M/F (circle)

Birth date: _____ Marital status: _____ Driver's license # _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

Which is the best number to contact you? _____ Occupation: _____

Email address: _____

Employer: _____ Parent (if under 18): _____

Emergency contact information:

Name: _____ Relation: _____

Phone: _____ cell/work: _____

Do we have permission to:

Leave a message on your answering machine? Yes / no Leave a message on your cell phone? Yes / no

Leave a message at work? Yes / no Discuss your medical condition with anyone? Yes / no

If we can discuss your medical condition with someone else, please give name(s): _____

(Note: If your spouse, child, or any other personal relation contacts us to speak about your medical condition, we will not be able to discuss your care unless their name is listed above.)

Billing information

Primary insurance: _____ Secondary insurance: _____

Subscriber's name: _____ Subscriber's birth date: _____

Relation to subscriber (circle): Self / Spouse / Child / Other

Notice of Privacy Practices

____ (Please initial): I have received, read and understand the Notice of Privacy Practices. A copy will be given to me upon request.

Assignment of Insurance Benefits

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I authorize Eric Munro MD or my insurance company, to release any information required to process my claim.
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient/Guardian signature: _____ Date: _____