DONNA RICHEY, M.D.

4201 Torrance Blvd. ,Suite 480
Torrance, CA 90503
Phone: 424.337.1800 Fax: 424.337.1801

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: __M __F Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other _____ How did you hear about us? _____

Primary Language _____ Interpreter Required? ☐ yes ☐ no

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial ____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

Have you recently changed or added to your health insurance?
☐ No, please verify your current information on file. ☐ *YES – Give receptionist your NEW card.*

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _

PHARMACY INFORMATION

Local Pharmacy Name _____ Address _____

Phone : (____)_____

Mail Order Pharmacy Name:_____

Phone : (____)_____

Authorization to Communicate Patient's Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, Indicate what kinds of information may be shared with each individual.

Name of Person Authorized To receive information	Relationship to Patient	Type of Information			
		All	Medical	Appt Only	Billing Only

Validation Code Word: _____ *(please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)*

Authorization and Consent for Health Care Services

I _____ authorize and direct Donna Richey, MD to provide diagnostic, preventative and therapeutic services which are deemed necessary for my health care.

Signature (Patient or Parent of Minor)_____Date: _____