Welcome to the Office of
L. Richard Shearer, M.D., Inc.

PATIENT INFORMATION Referred By: ___________________________

Date: ________________ ***Did you see our ad:*** Yes No

Patient's Name: ____________________________________ Address: ____________________________________

City: ________________________________ State: _______ Zip: ___________ Phone: ____________________

Social Security #: ______________________________ Birth date: _________________ Age: ___________

Employer: ____ Occupation: __________________________________

Work Address: ____ Work Phone: ________________________

Marital Status: S/M/W/Div/Sep Spouse's Name: ________________________________

Spouse's SS#: _____________________________________ Birth Date: ________________

Employer: ____ Occupation: __________________________________

(if the patient is a minor)

Mother's Name: ____ Social Security #: _______________________

Mother's Employer: ____ Home Phone: ___________________

Employer's Address: ____ Work Phone: ___________________

Father's Name: ____ Social Security #: ______________________

Father's Employer: ____ Home Phone: ___________________

Employer's Address: ____ Work Phone: __________________

** IN CASE OF EMERGENCY **

Contact: ____

INSURANCE INFORMATION

Insurance Company: ____ Subscriber #: ________________________

Insurance Company: ____ Subscriber #: ________________________

Medicare #: ____ Medi Cal #: ___________________________

Payment is expected at the time of your visit. VISA and MasterCard are accepted. Dr. Shearer is not a participating provider for any insurance company, but he is a provider and will bill for Medicare. A superbill will be provided so that you may bill your insurance company.

I agree that despite medical insurance coverage, I am financially responsible for all incurred medical expenses.

SIGNATURE: ____ DATE: ______________________