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**Please PRINT clearly with BLACK INK**

Date of Appointment: \_\_\_\_\_ Referring Physician or Primary Care Physician \_\_\_\_\_  
Patient's Legal Name: \_\_\_\_\_ Name pt goes by: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
City: \_\_\_\_\_ State : \_\_\_\_\_ Zip : \_\_\_\_\_  
Home #: (\_\_\_\_) \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ Mobile #: (\_\_\_\_) \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Patient's Occupation: \_\_\_\_\_ Patient's Employer: \_\_\_\_\_

**Emergency**

Contact : \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_

INSURANCE #1 POLICY HOLDER     Self     Spouse     Parent     Other

Insurance Policyholder's Name (If not patient) : \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Address (If different from above): \_\_\_\_\_

City: \_\_\_\_\_ State : \_\_\_\_\_ Zip: \_\_\_\_\_ Contact Ph#: \_\_\_\_\_

INSURANCE #2 POLICY HOLDER     Self     Spouse     Parent     Other

Insurance Policyholder's Name (If not patient) : \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Address (If different from above): \_\_\_\_\_

City: \_\_\_\_\_ State : \_\_\_\_\_ Zip: \_\_\_\_\_ Contact Ph#: \_\_\_\_\_

**Please read and sign below: I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-shares and deductibles will be collected. It is the patient's responsibility to notify this office if your insurance plan(s) require prior authorization before services are rendered. **If the patient is a minor form must be signed by a Legal Guardian or Responsible Party.**

**IF PRIOR AUTHORIZATION IS REQUIRED AND NOT OBTAINED, YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.**

Patient / Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_