

**THOMAS R. VECCHIONE, M.D., INC.**  
**3399 FIRST AVENUE \* San Diego, CA 92103 (619) 297 - 4433**

Full Name: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc.Sec# \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**You may contact me via:** \_\_\_\_\_  
**(please initial) Phone Cell Work# E-mail Voice mail**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_  
Referred by: \_\_\_\_\_ PCP: \_\_\_\_\_

**If Patient is A Minor:**  
**Responsible Party:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**In Case of Emergency Please Notify:** \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**INSURANCE INFORMATION: (please provide your card so we may duplicate)**

**Primary Insurance:** \_\_\_\_\_  
Address & Phone#: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID# \_\_\_\_\_ GRP# \_\_\_\_\_

**DOES YOUR INSURANCE REQUIRE A REFERRAL? Y \_\_\_ N \_\_\_ . Co Pay Amt: \$ \_\_\_\_\_**

**Secondary Insurance:** \_\_\_\_\_  
Address & Phone# \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ ID# \_\_\_\_\_ GRP# \_\_\_\_\_

**Assignment of Benefits and Release of Information:**

I do hereby authorize Thomas R. Vecchione, M.D. to release any necessary medical information to the named insurance carrier(s) for the purpose of utilization review, claims administration and/or financial audit. This authorization remains effective from the date of signing until revoked in writing. I do hereby assign Thomas R. Vecchione, M.D. all monies to which I am entitled for medical and or surgical expense related to services rendered. I understand that I am fully responsible to said physician for any charges not covered by my insurance.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_.

**Effective April 14, 2003: HIPPA – NOTICE OF PRIVACY PRACTICE**  
By signing this statement, I \_\_\_\_\_ on this day of \_\_\_\_\_  
hereby acknowledge receipt of Dr. Thomas R. Vecchione M.D. Notice of Privacy  
Practices.