Dr. Brad West
244 Oak Meadow Dr. Los Gatos, CA 95032
(831) 332-0143 and (408) 354-2323

INFORMATION FOR HEALTH RECORD

DATE _____ EMAIL _____

PATIENT'S FULL NAME _____
(FIRST) (MIDDLE) (LAST)

BIRTHDATE _____ PLACE_____ _____ AGE _____

ADDRESS _____
(STREET) (CITY) (ZIP)

HOME PHONE # _____WORK/CELL PHONE #_____

OCCUPATION/EMPLOYER _____ _Location_____

Marital Status: M S W SPOUSE'S NAME_____# of Children/Ages:_____
(OR PARENT IF PATIENT IS A MINOR)

IN CASE OF EMERGENCY _____
(NAME) (Relationship) (PHONE)

DRIVERS LICENSE # _____(for checks) Credit Card #_____Exp____
Sec code____ (HIPAA protected)
PERSON RESPONSIBLE FOR PAYMENT _____($50 charge for missed appointments without 48 hours notice)

RELATIONSHIP TO PATIENT _____

WHO RECOMMENDED US TO YOU? _____

INSURANCE _____
(we are a low cost "cash practice", meaning we do not bill insurance but provide a Superbill for your own submission and files. A paper check is the preferred payment form, thank you.)

PAYMENT IN FULL IS EXPECTED AT THE TIME OF THE OFFICE VISIT.
If this is not possible, please let us know prior to the visit so that arrangements may be discussed.

REASON FOR VISIT:

SIGNATURE _____