Los Alamitos Family Health & Wellness
Dr. Jennifer Kim Loomis
3801 Katella Ave Suite 222
Los Alamitos, CA 90720

WELCOME, please tell us about yourself. Referred by: _____

Last Name: _____ Suffix: _____ First Name: _____

Middle Name: _____ Nickname: _____

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____

Phones Home: _____ Work: _____

Cell: _____ Fax: _____

Preferred Number: _____

E-Mail Address: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Social Security Number: _____

Spouse Name: _____ Phone: _____

Spouse Birth Date: _____ Alternate Phone: _____

Who can we contact in case of an emergency? (If it is the same as your spouse you can leave this blank):

_____ What is their relationship to you?: _____

Phone: _____ Alternative Phone: _____

Are you employed?: _____ Where?: _____

Address: _____

We have the ability to transmit prescriptions to your pharmacy electronically if they participate in E RX.

What is your pharmacy name?: _____ Phone: _____

Is this a mail order pharmacy?: _____ Did they give you a fax form?: _____

Please tell us about your insurance, if you have given the receptionist your insurance card/s you can leave this part blank.

Primary Insurance: _____ ID #: _____ Group #: _____

Customer Service Phone: _____ Authorization phone: _____

Claim Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Customer Service Phone: _____ Authorization phone: _____

Claim Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to Los Alamitos Family Health and Wellness.

This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release all information to secure the payment. I hereby consent to and authorize all treatment and medical services by the physician and staff of this office, as they deem necessary. I authorize the release of any information regarding my history, treatment, findings, X-ray findings and other clinical studies and diagnosis that this office deems necessary.

Signed: _____ Date: _____

Ancillary Services Notice

We use Los Alamitos Medical Center Laboratory Services as our Reference Laboratory. Your insurance may require you to utilize another laboratory. We do not know what your insurance requirements are. If you need your lab work to be sent to another reference laboratory you must tell the nurse. If you do not specify a laboratory, your lab work will be sent to Los Alamitos Medical Center Laboratory.

I have read and understand Dr. Kim Loomis' Ancillary Services Notice.

Signed: _____ Date: _____