



# Spectrum Care & Wellness

255 E. Orange Grove Ave Suite A, Burbank, CA 91502 | Phone: 818.848.3333 | Fax: 818.848.3337  
Catherine Chern, MD | Christine Szeto, MD

## PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

SSN:  -  -  Marital Status:  Single  Married  Separated  Widowed  Widower  Domestic Partner

Primary language: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred phone#: \_\_\_\_\_  Mobile  Home Alternate phone #: \_\_\_\_\_  Mobile  Home

Email Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## GUARANTOR INFORMATION: (Main Subscriber of Insurance)

Guarantor Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN:  -  -  Phone #: \_\_\_\_\_

DOB: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION:

Contact Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Preferred phone#: \_\_\_\_\_  Mobile  Home Alternate phone #: \_\_\_\_\_  Mobile  Home

## INSURANCE INFORMATION:

Primary Insurance: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber SSN:  -  -  DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Subscriber SSN:  -  -  DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Additional Notes: \_\_\_\_\_

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