Santa Cruz
Direct Primary Care

General Information:

Please provide the following information for our clinic. Insurance information is only for information for specialty and laboratory referrals and other outside orders.

Patient Name: _____

Date of Birth: _____

Responsible Party: ☐ Self ☐ Other: _____

Address: _____
_____
_____

Insurance Provider/Type: _____
Group Number: _____ Effective Date:_____
ID Number: _____
Claims Address: _____
_____

Contact Preference: ☐ Cell phone: _____
☐ Home phone: _____

Email address: _____
Work phone: _____

Emergency Contact: _____
Phone: _____
Relationship to patient: _____

Recurrent Billing Information:

Please complete if you have not submitted information on the website for recurrent billing, and we will help to set up the account for you on your first visit.

Name on Account: _____

Plan:

☐ 21 - 44 y.o. ($59) # of Patients: _____
☐ 45 - 64 y.o. ($79) _____
☐ 65 y.o. or greater ($99) _____
☐ Child ($20 with adult) _____

Method of Payment: ☐ Checking ☐ Savings Account number: _____
Routing number: _____

Note: if using checking or savings account, you will have 2 small debits (less than $1.00 each) and an email sent to verify your account. Please send back the email with the numbers of the credits to confirm your account is active. Thanks!

OR -- Method of Payment: ☐ Visa ☐ MasterCard ☐ American Express
Account number: _____
Expiration date: _____CVV#_____

Billing Address: ☐ Same as above
☐ Other: _____
_____
_____