Gregory J. Wiener, M.D.

353 Church Ave Suite A
Chula Vista, CA 91910
(619) 585-8883

PATIENT INFORMATION		
Patient Name:	Gender: ☐ Female ☐ Male	DOB: / /
	SS#:	
Patient Address:	☐ White /Caucasian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Race: ☐ Native Hawaiian or Other Pacific Islander ☐ Declined	
	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Cell #: ( )	Preferred Language:	
Home #: ( )	Work #: ( )	

PRIMARY CARE PHYSICIAN			
Physician Name:			
Address:	City:	State:	Zip:
Is this the referring Physician? ☐ YES ☐ NO	Phone #:	Fax #:	
If No, Please list the Referring M.D. :			

INSURANCE INFORMATION	
Primary Insurance:	Secondary Insurance:
Insured Person:	Insured Person:

I hereby authorize Gregory J. Wiener, M.D., P.C. to treat the patient listed above. I hereby authorize payment directly to the above name physicians of the amount due me in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I authorize any physician, hospital, or clinic to provide full detail of my or my dependent medical history and treatment to the above named physicians. In addition, I authorize the physician's listed above to release any information necessary to assist in medical treatment and / or insurance payment.

X	
Signature of Patient	Date Signed