CALIFORNIA
HERNIA
SPECIALISTS
TODD S. HARRIS, MD

PLEASE READ CAREFULLY
THIS IS YOUR MOST RECENT DEMOGRAPHIC AND BILLING INFORMATION FOR OUR RECORDS. PLEASE CHECK ALL INFORMATION BELOW. YOUR ARE RESPONSIBLE FOR ALL INFORMATION BELOW BEING CORRECT.
PLEASE INFORM OUR STAFF OF ANY REQUIRED CHANGES.

Name :	**Medical Record # :**
Email:	**Birth Date :** **Age :**
How did you hear about us?	
Address :	**Social Security # :**
	Sex :
City/State/Zip :	**Emergency Contact # :**
Home Phone # :	**Emergency Contact Name:**
Work/Day Phone # :	**Cell # :**
Primary Care Name:	**Pharmacy :**
Primary Care Phone:	**Address :** Pharmacy
Meaningful Use reporting: Age 65 + Have You Ever Received a Pneumoccal Vaccine - Yes ◯ No ◯ Age 50 + Have You Ever Recv'd Flu Immunization - During Flu Season Sept - Feb - Yes ◯ No ◯ Age 18 + Do You CURRENTLY Smoke or Use Tobacco - Yes ◯ No ◯ Age 18 + Have You Ever Received Advice to Quit Smoking or Quit Tobacco Use - Yes ◯ No ◯	**Phone/ Fax:** Pharmacy
INSURANCE CARRIER	**GROUP#**
INSURED	
INSURED ID	

Kindly acknowledge below that the above means of communication are acceptable means of communication for CAHS to communicate with you and that the above information is correct. In the event that you wish to change, restrict, add or remove any of the above means of communication, you agree by your signature below that it is your responsibility to notify CAHS of such change, restriction, addition or deletion by requesting and filling out a Confidential Channel Communication Request form provided by California Hernia Specialists.

I hereby agree that the above means of communication are acceptable means for you to communicate with me and that the above medical and billing information is correct.

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Print/Sign Name