Irvine Odyssey Medical Center
22 Odyssey Suite 115
Irvine, CA 92618
Telephone: (949) 988-7550 **Fax**: (949) 988-7551

Patient Authorization Form

Patient Name:		
Appointment Date:	Time:	Provider:
Mailing Address (include City, State and Zip):		
Street Address (if different than mailing):		

Home Phone:	Cell Phone:
OK to leave a message at home? YES / NO	

Date of Birth:	Social Security Number: - -
Marital Status:	Email Address:

Primary Insurance:	Subscriber Name:
Address:	Subscriber ID:
Phone Number:	Date of Birth:
Group Name:	Group Number:

Secondary Insurance:	Subscriber Name:
Address:	Subscriber ID:
Phone Number:	Date of Birth:
Medigap? Supplemental?	Group Number:

Employer Name:	Work Number:
Address:	OK to leave a message at work? YES / NO

Emergency Contact Name:	Pharmacy Name:
Emergency Contact Address:	Pharmacy Address:
Phone Number:	Pharmacy Number:

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Irvine Odyssey Medical Center for all my insurance claims related to services received. I agree to pay any and all charges that exceed or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: ______________________________

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: ______________________________