OFFICE AND PRACTICE OF J. BERNARD CORDOBA, MD

PATIENT INFORMATION FORM

UPDATED APRIL 2020

Please read and sign this patient responsibility and consent for medical treatment form.

Name _____ Date_____ Sex: M F

Home Phone _____ Cell Phone_____

Address_____

City_____ State_____ Zip Code_____

Marital Status_____

Responsible Party for Payment Information

Responsible Party Name (please print) _____

Address _____ City/State _____ Zip_____

Preferred Contact Phone # ( ) _____ ___ Home ___ Cell

____ Work _____ OK to leave a message?

Payment in full is required at the time of service. Any financial concerns should be discussed with Dr. Cordoba prior to services being rendered.

I HAVE READ THE ABOVE STATEMENT AND AGREE TO BE PERSONALLY RESPONSIBLE FOR ALL CHARGES AND FEEES. ADDITIONALLY, I GIVE MY CONSENT FOR MEDICAL TREATMENT.

_____ _____

Signature of Patient or Responsible Party Date