Cynthia Soto, M.D.
399 E Highland Ave, Ste 223
San Bernardino, CA 92404
(909) 475-5200

BIOGRAPHICAL INFORMATION SHEET

Please complete these forms and return it to the receptionist. Thank you. (Por Favor llene y firme estas formas. Regrese estas formas a la recepcionista cuando termine. Gracias)

Date (Fecha): _____/_____/_____

1. PATIENT INFORMATION

Last Name (Apellido): _____ First Name (Nombre):_____

Address (Domicilio): _____

City/State/ZIP _____
(Cuidad, Estado, Codigo Postal)

Telephone (Telefono) (_____)_____-_____

Date of Birth: _____/_____/_____ Social Security #_____-_____-_____
(Fecha De Nacimiento) (# de Seguro Social)

Single(Soltera)_____ Married (Casada)_____ Divorced (Divorciada)_____

Widowed (Viuda)_____ Separated (Seperada)_____ Minor (Menor de edad)_____

Employer (Empleador) _____

Employer Phone Number (Numero de telefono de empleador) (_____) _____

Occupation (Ocupasion) _____

Emergency Contact - In case of Emergency, who should we contact? (En caso de una emergencia, a quien debemos llamar?)

Name (Nombre) _____

Relationship to patient (Relacion con el paciente):_____

Home Telephone Number (Numero de Casa): (_____) _____

Work Telephone Number (Numero De el Trabajo: (_____)_____

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2. RESPONSIBLE PARTY (PERSONA RESPONSIBLE):

Name (Nombre): _____ D.O.B:_____/_____/_____
(Fecha De Nacimiento)

Relationship to Patient (Relacion con el paciente):_____

Occupation (Ocupasion):_____

SS# (Seguro Social) _____/_____/_____

3. INSURANCE INFORMATION (INFORMACION DE SU ASEGURANZA)

Name of Insured: _____
(Nombre de quien le pertenece la aseguranza)

Name of Insurance: _____ Policy #_____ Group #_____
(Nombre de Aseguranza) # de Polisa

4. AUTHORIZATION AND RELEASE (AUTORIZACION):

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I hereby authorize the physician to release any information acquired in the course of my examination and treatment.

I (**Patient and/or Guardian**) am an eligible member of this date of service of a health plan and a copy of the benefits card is attached to this document. Signature of the responsible party below acknowledges full financial responsibility or services rendered to me if it is determined I am not eligible on the date of service in question or if services rendered is determined to be non-covered benefit under the plan provisions.

I hereby irrevocable authorize payment directly to the above named corporation/physician, benefits otherwise payable to me but not to exceed the corporation's/ physician's regular charge due as a result of this claim. I understand I am financially responsible to the corporation/physician for charges not covered.

Signature: _____Date_____
(Firma) (Fecha)

CYNTHIA J. SOTO, M.D.
NEUROLOGY

Medical Questionnaire

Name: _____

Date of Birth: _____

What is your main concern today?_____
_____
_____

Please circle if you have any of the following medical conditions:

Diabetes mellitus	High blood pressure	Heart disease
Headaches	Seizures	Lung disease
Stroke	Neuropathy	Low back pain
Neck pain	High cholesterol	

Other Medical Problems:_____
_____
_____

Please List Any Surgeries:_____
_____
_____

Please List Any Medications You Take (If you already have a written list of medications, please give it to the medical assistant to photocopy):_____
_____
_____
_____

Do you smoke?	Yes	No	How much?
Do you drink alcohol?	Yes	No	How much?
Do you use any street drugs?	Yes	No	Which ones?

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