The West Coast
Center Of Excellence
For Pectus Deformities

BARRY E. LOSASSO, M.D., F.A.C.S., F.A.A.P.
General and Thoracic Surgery
of Infants and Children

Patient's Information

Full Legal Name: *(Last, First Middle)*		Date of Birth:	Sex:
Address:	City:	State:	Zip:
Primary Phone : *(with area code)*	Patient employer: *(if applicable)*		
Alternate Phone : *(with area code)*	Business Phone:		
E-mail address:	Occupation:		

Parent/Guardian/Spouse

Full Legal Name: *(Last, First)*	Date of Birth:	Relation to Patient:	
Address: *(If different from above)*	City:	State:	Zip:
Primary Phone : *(with area code)*	Employer: *(if applicable)*		
Alternate Phone : *(with area code)*	Business Phone:		
E-mail address:	Occupation:		

Parent/Guardian Information

Full Legal Name: *(Last, First)*	Date of Birth:	Relation to Patient:	
Address: *(If different from above)*	City:	State:	Zip:
Primary Phone : *(with area code)*	Employer: *(if applicable)*		
Alternate Phone : *(with area code)*	Business Phone:		
E-mail address:	Occupation:		

Insurance Information

Insurance Company Name:	ID#	Insurance Holder:

PCP (Primary Care Physician)

Name	Phone :	Fax:

Emergency Contact

Full Legal Name: *(Last, First)*	Relationship to patient:	Phone:

I am the ☐ **Patient** ***(self)*** ☐ **Parent** ☐ **Foster Parent** ☐ **Legal Guardian**

I am financially responsible for services and supplies rendered and there is a fee for returned checks. I authorize the release of any information necessary to process my claim and the payment if benefits to Barry E. LoSasso, MD, Inc. I may be charged for missed appointments and acknowledge receipt of Notice of Privacy Practices. I understand medical doctors are licensed and regulated by the Medical Board of California.

Payment is expected at the time of service.

X _____ Signature

_____ Date