Santa Cruz
Direct Primary Care

General Information:

Please provide the following information for our clinic. Insurance information is only for information for specialty and laboratory referrals and other outside orders.

Patient Name: _____

Date of Birth: _____

Responsible Party: ☐ Self Other: _____

Address: _____
_____
_____

Insurance Provider (or you can attach a copy of your card):
Plan: _____
Group Number: _____ Effective Date: _____
ID Number: _____
Claims Address: _____
_____

Contact Preference: ☐ Cell phone: _____
☐ Home phone: _____

Email address: _____
Work phone: _____

Emergency Contact: _____
Phone: _____
Relationship to patient: _____

Recurrent Billing Information:

Please complete if you have not submitted information on the website for recurrent billing, and we will help to set up the account for you on your first visit.

Name on Account: _____

Membership Plan: (# of Patients)

☐ 20 - 44 y.o. ($69) _____
☐ 45 - 64 y.o. ($89) _____
☐ 65 y.o. or greater ($109) _____
☐ Child ($30 with adult) _____
☐ Assisted/ Skilled Nursing ($160) _____

Method of Payment: ☐ Checking ☐ Savings
Account number: _____
Routing number: _____

OR -- Method of Payment: ☐ Visa ☐ MasterCard ☐ American Express
Account number: _____
Expiration date: _____CVV#_____
Zip code associated with card:_____

Billing Address: ☐ Same as above
☐ Other: _____
_____