PATIENT INFORMATION SHEET **PLEASE PRINT**

DATE _____ **DOCTOR** _____ **ACCOUNT #** _____

LEGAL NAME _____
Last First Middle

DATE OF BIRTH ____/____/____ **AGE** _____ **SEX M / F** **MARITAL STATUS: S / M / W / D**

HOME ADDRESS _____
Number Street City State Zip

HOME PHONE (____)_____ **CELL PHONE** (____)_____

****CIRCLE ONE:**

RACE: American Indian Black/African American Native Hawaiian White Unknown

LANGUAGE: English Spanish Armenian Chinese French German Italian Japanese

ETHNICITY: Hispanic Non-Hispanic Unknown

PERMISSION TO LEAVE A MESSAGE: Yes ____ No____ **EMAIL ADDRESS:** _____

BEST FORM OF CONTACT (CIRCLE): EMAIL CELL PHONE OTHER_____

SOCIAL SEC # _____ **DRIVER LIC #** _____

EMPLOYER _____ **BUS. PHONE** (____)_____

SPOUSE NAME_____**CELL PHONE**_____**WORK PHONE**_____

EMERGENCY CONTACT_____**PHONE** (____)_____**RELATIONSHIP**_____

DUE TO PRIVACY LAWS DO YOU GIVE THIS OFFICE PERMISSION TO SPEAK TO ANYONE OTHER THAN YOURSELF:
YES___ NO___ NAME: _____

REFERRED BY _____ **PHONE** (____)_____
(Doctor or Friend)
ADDRESS _____
Number Street City State Zip

****RESPONSIBLE FOR BILL: SELF, PARENT, OR GUARDIAN INFORMATION IF NOT THE SAME**

NAME _____ **RELATIONSHIP**_____ **PHONE** (____)_____
(Self or Other)
ADDRESS _____
Number Street City State Zip

INSURANCE INFORMATION
INSURANCE _____ **SUBSCRIBER/POLICY HOLDER**_____
(Name) **(Name)**
POLICY ID# (or Social Security #) _____ **GROUP ID#** _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS. I HAVE REQUESTED THE DOCTOR BILL MY INSURANCE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO **OB&GYN MEDICAL GROUP OF VERDUGO HILLS**. IF ELIGIBILITY FOR INSURANCE BENEFITS IS NOT ESTABLISHED, OR SERVICES ARE NOT COVERED BY MY INSURANCE, I WILL ASSUME FULL RESPONSIBILITY FOR CHARGES INCURRED FOR SERVICES RENDERED. I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW ALL RULES AND RESTRICTIONS OF MY INSURANCE POLICY, TO KNOW WHICH HOSPITAL, EMERGENCY ROOMS, LABORATORIES, X-RAY DEPARTMENTS AND SPECILIST PROVIDERS WHICH ARE ASSIGNED TO ME ACCORDING TO MY INSURANCE POLICY RULE.

THERE WILL BE A $25.00 CHARGE FOR ALL RETURNED CHECKS.

SIGNED: _____**DATE**_____