SANTA MONICA
Gynecology & Obstetrics

PATIENT REGISTRATION FORM

ACCOUNT #: _____ REFERRED BY: _____ TODAY'S DATE: _____

NAME: _____ *(MAIDEN NAME)*: _____ AGE: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____ EMAIL: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

DATE OF BIRTH: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER

OCCUPATION: _____ EMPLOYER: _____ PHONE: (_____)_____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE *(Parent if under 18)*: _____ PHONE: (_____)_____

OCCUPATION: _____ EMPLOYER: _____ PHONE: (_____)_____

BUSINESS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

NEAREST FRIEND OR RELATIVE *(Not living with you)*: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____ PHONE: (_____)_____

INSURANCE

MEDICAL INSURANCE: ☐ YES ☐ NO DO YOU HAVE MEDI-CAL? ☐ YES ☐ NO

NAME OF COMPANY: _____

POLICY #: _____ GROUP # *(If applicable)* _____

OFFICE POLICY

The patient is directly responsible for FULL PAYMENT EACH TIME SERVICE IS PROVIDED. We will provide you with a completed super bill to file with your insurance company for reimbursement of the charges you paid.

If you are insured by a company that contracts with your doctor for insurance billing, PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST so that it may be copied and your benefits verified. WE CANNOT BILL YOUR INSURANCE WITHOUT A COPY OF YOUR CARD ON FILE. I authorize the release of any medical information or other information necessary to process this claim.

Should you have any further questions regarding our policies, we will be happy to discuss them with you. We appreciate your selection of this office to serviceyour health care needs, and we will do all we can to provide you with the very best care possible.

PATIENT or RESPONSIBLE PARTY SIGNATURE: _____