

# LAGUNA BEACH OBSTETRICS & GYNECOLOGY

31852 Pacific Coast Highway Suite 200

Laguna Beach, CA 92651

## PATIENT INFORMATION

<b>Patient</b>		Last Name	First Name	Middle Name	Today's Date
<b>Address</b>		Street	City	State	ZIP Code
Birth Date	Email	Driver's License Number	Social Security Number		Work Phone
<b>Referred By:</b>		Which Phone Number would you like us to use to contact you? Pls. Circle			Cell Phone
		Home	Work	Cell	

<b>RESPONSIBLE PARTY</b> (If other than patient, please fill out completely)					Social Security Number
<b>Relation to Patient</b>					Birth Date
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian					
<b>Name</b>		Last Name	First Name	Middle Name	Home Phone
<b>Address</b>		Street	City	State	ZIP Code
					Work Phone
					Cell Phone

### PERSON TO CONTACT IN CASE OF EMERGENCY

Name	Relationship	Phone Number
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**Please circle your insurance type:**    **PPO**    **HMO**    **Medicare**    **Other** \_\_\_\_\_

### INSURANCE INFO

Primary Insurance Company	Member ID	Group Number
Subscriber's Name	Birth Date	Effective Date
Secondary Insurance Company	Member ID	Group Number
Subscriber's Name	Birth Date	Effective Date

### ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by assignment. A photostat of this authorization is acceptable with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

\_\_\_\_\_  
INSURED'S SIGNATURE - *Required*

\_\_\_\_\_  
Date

\_\_\_\_\_  
SIGNED: Patient or Parent of Minor