SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC

Maternal Fetal Medicine

REGISTRATION

(PLEASE PRINT)

Date_____ Home Phone (____)_____ Cell Phone (____)_____

PATIENT INFORMATION

Name _____ Soc. Sec.#_____
Last Name First Name Middle Initial

Address _____E –Mail_____

City_____State_____Zip_____

Sex ☐ M ☐ F Age _____Birthdate _____ ☐ Married ☐Widowed ☐ Single ☐Minor ☐Separated ☐ Divorced Partnered for _____years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone (____)_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____Birthdate_____Soc.Sec#_____

Address (if different from patient's) _____Phone(____)_____

City_____State_____Zip_____

Person Responsible Employed by _____Occupation_____

Business Address_____Business Phone (_____)_____

Insurance Company_____

Contact #_____Group #_____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____Birthdate_____ Relation to Patient_____

Address (if different from patient's)_____Phone(____)_____

City_____State_____Zip_____

Subscriber Employed by_____Business Phione (____)_____

Insurance Company _____Soc. Sec.# _____

Contact # _____Group #_____Subscriber # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____and assign directly to
Name of Insurance Company (ies)

SAN GABRIEL VALLEY PERINATAL MED, GRP, all insurance benefits , if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above- named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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