

**PATIENT INFORMATION**

Name \_\_\_\_\_  
Last Name First Name Middle Name Maiden Name

Address \_\_\_\_\_  
Street Apt. No. City & State Zip Code

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status S M W D SS# \_\_\_\_\_

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Suite No. City & State Zip Code

Spouse's Name \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Referred By \_\_\_\_\_

Name & Phone Number of Nearest Relative Not Living With You \_\_\_\_\_

**INFORMATION ON PERSON RESPONSIBLE FOR BILLING**

Guarantor Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt. No. City & State Zip Code

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

**INSURANCE INFORMATION**

**Do you have insurance to cover the fees for services rendered?**  Yes  No

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured .....	Name of Insured .....
Primary Insurance .....	Secondary Insurance .....
Insurance Address .....	Insurance Address .....
ID # .....	ID # .....
Group # .....	Group # .....
Insured's Date of Birth .....	Insured's Date of Birth .....

**AUTHORIZED PERSON'S SIGNATURE**

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment (if applicable) of my Medicare benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Redlands Obstetrics and Gynecology Associates. I understand that I am responsible for payment regardless of insurance coverage.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date