

Women's Care of Beverly Hills Medical Group

Ruth Cousineau, M.D. Robert Katz, M.D. Jay Goldberg, M.D.
 Suzanne Gilberg-Lenz, M.D. _____ _____

PATIENT INFORMATION

LAST NAME		FIRST NAME & INITIAL	
ADDRESS LINE			
CITY		STATE	ZIP
HOME PHONE		SOCIAL SECURITY NO.	
WORK PHONE		CELL PHONE	
EMAIL ADDRESS			
DATE OF BIRTH	AGE	MARITAL STATUS	<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED
REFERRING DOCTOR		PHONE	
EMERGENCY NOTIFICATION		PHONE	
PATIENT'S EMPLOYER		OCCUPATION	
EMPLOYER'S ADDRESS			
CITY	STATE	ZIP	PHONE NO.
SPOUSE NAME		SOCIAL SECURITY NO.	
SPOUSE'S EMPLOYER		WORK PHONE NO.	
NAME RELATIVE		PHONE	
NAME FRIEND		PHONE	
INS'D PERSONS NAME		SOCIAL SECURITY NO.	
INSD'S EMPLOYER		WORK PHONE NO.	
RELATION TO INS'D PERSON		PHONE	

INSURANCE #1 INFORMATION

INSURANCE #1 NAME			
ADDRESS		INS #1 PHONE	
POLICY HOLDER'S LAST NAME	FIRST NAME	RELATIONSHIP	
ID # (NO.)	GROUP NO.	SUBSCRIBER'S DATE OF BIRTH	

INSURANCE #2 INFORMATION

INSURANCE #2 NAME			
ADDRESS		INS #2 PHONE	
POLICY HOLDER'S LAST NAME	FIRST NAME	RELATIONSHIP	
ID # (NO.)	GROUP NO.	SUBSCRIBER'S DATE OF BIRTH	

SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.	Signature	Date
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	Signature	Date
I understand by not supplying my complete insurance information or no insurance information, I will be responsible for my account balance.	Signature	Date