# Women's Care of Beverly Hills Medical Group

- ❑ Ruth Cousineau, M.D.
- ❑ Suzanne Gilberg-Lenz, M.D.
- ❑ Robert Katz, M.D.
- ❑ ____________________
- ❑ Jay Goldberg, 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 | ❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ 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



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