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**West Coast Ob/Gyn, Inc.**
7695 Cardinal Court, Suite 240
San Diego, CA 92123

## Patient Registration

Patient's Name:_____
LAST FIRST MIDDLE

Home Address:_____
Number& street apt city state zip

Number you would like Doctor to call you with results:_____

Cell Phone:_____ Date of Birth:_____ Social Sec#_____

Marital Status: ☐M ☐W ☐S ☐D Driver's Lic#:_____ E-mail:_____

Employer:_____ Occupation:_____

Employer Address:_____
Number & street suite city state zip

**Insured Person** ☐Please check here if you are the insured person

Name:_____
Last first Middle

Date of Birth:_____ Social Sec#_____

Employer:_____ Occupation:_____

Employer Address:_____

Work Phone_____

## Emergency Contact

1. Name:_____ Phone Number:_____
2. Name:_____ Phone Number:_____

**Please provide the Front Desk with a copy of your insurance card/ information**

**How were you referred to our office?**_____

## Assignment/Authorization

I hereby authorize payment of insurance benefits to be made to West Coast Ob/Gyn, Inc. for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by my insurance. In the even of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize the release of any medical information necessary to process my insurance claims. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.

**Signature:**_____ **Date:**_____