Jose M.Medrano,M.D.

Obsterics and Gynecology / Laser and Gynecologic Surgery

PLEASE PRINT LEGIBLY

Today's Date : ***Best Contact Phone:*** ☐ Cell ☐ Home ☐ Work

Patient Information

Name ______________________________ Soc.Sec.# __________

Last Name First Name

Birthday ______________ ☐ Female ☐ Male ☐ Single ☐ Married ☐ Separated ☐ Divorced

Adddress ______________________________

Street City State Zip Code

Home Phone __________ Cell Phone __________ Work Phone __________

Employer ______________________ Occupation __________

Employer Address ______________________________

Street City State Zip Code

Whom may we thank for referring you? ______________________________

Emergency Contact : ______________________________

Name Relationship Phone#

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________

Name of Insurance Company

and assign directly to Dr. Jose M. Medrano 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 hereby this signature on all insurance submissions.

____

Responsible Party Signature Relationship Date

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices from Jose M. Medrano, M.D.

______________________ ______________________

Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

____

Date

Physical Exam(OFFICE USE ONLY)

HT __________ WT __________ BP __________ P __________

MEMO:

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