Newport Beach OB/GYN Medical Group, Inc.
Patient Demographics

This information is confidential. We appreciate your cooperation in completing this form thoroughly. Please print legibly.

Patient's Name: ______________________________ Date of birth: ______________ Age: ________
Last First M

Marital Status: Single Married Divorced Widow

Address: ______________________________

Driver's License: ______________________________

City: ______________ ST: ______ ZIP: __________

Social Security: ______________________________

Phone Number: ______________________________

Occupation: ______________________________

Cell Number: ______________________________

Employer's Phone: ______________________________

Employer's Name: ______________________________

E-Mail Address: ______________________________

Spouse's Name: ______________________________ Spouse's Phone Number: ______________________________

Spouse's Social Security #: ______________________ Spouse's Date of Birth: ______________________________

Spouse's Employer's Name: ______________________ Spouse's Employer's Phone: ______________________________

****In case of emergency, nearest friend or relative not living with you:**

Name: ______________________________ Relationship to Patient: ______________________________

Phone Number: ______________________________

****If responsible party is other than patient, please complete this section:**

Responsible Party: ______________________________ Relationship to Patient: ______________________________

Address: ____

Employer: ______________________________ Employer #: ______________________________

Driver's License: ______________________________ Social Security: ______________________________

Medical Insurance Information:

Primary Medical Insurance Company: ______________________________ Effective Date: ____________

Type of Insurance: HMO PPO Medicare Other ______________ Subscriber: ______________________________

If HMO, Name of Medical Group & Hospital: ______________________________ Policy Number: ______________________

Address: ______________________________ Phone Number: ______________________________

Secondary Medical Insurance Company: ______________________________ Effective Date: ____________

Type of Insurance: HMO PPO Medicare Other ______________ Subscriber: ______________________________

If HMO, Name of Medical Group & Hospital: ______________________________ Policy Number: ______________________

Address: ______________________________ Phone Number: ______________________________

- I authorize and consent to examination and treatment of the above-named patient as deemed necessary by: Newport Beach OB/GYN and staff.
- I authorize the release of medical information necessary to process this claim.
- I authorize the payment of medical and/or surgical benefits to physician or supplier.
- I acknowledge that I am responsible for payment of all charges in full

Signed: ______________________________ Date: ______________________

I hereby authorize treatment for my child, who is under the age of 18, to be treated by Newport Beach OB/GYN and staff.

Signed: ______________________________ Date: ______________________