

# Richard Bardowell, M.D.

Obstetrics • Gynecology • Infertility

2701 W. Alameda Ave., Suite 303  
Burbank, CA 91505

(818) 843-3100

## PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ RELIGION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ MAIDEN NAME: \_\_\_\_\_ SOC. SECURITY #: \_\_\_\_\_

OCCUPATION: EMPLOYER: \_\_\_\_\_

BUS. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

BUS. PHONE: \_\_\_\_\_ HOW LONG: \_\_\_\_\_ DRIVER'S LICENSE NO: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ SOC. SECURITY #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

AGE: \_\_\_\_\_

(If patient is a minor, name of responsible parent or guardian)

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_ RELIGION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

BUS. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BUS. PHONE: \_\_\_\_\_ HOW LONG: \_\_\_\_\_ DRIVER'S LICENSE NO: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN SPOUSE)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

PATIENT REFERRED BY: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INSURANCE NAME: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

CERTIFICATE NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

CERTIFICATE NO: \_\_\_\_\_ GROUP NO: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I hereby authorize \_\_\_\_\_ to pay for surgical and/or medical benefits directly to RICHARD BARDOWELL, M.D. 2701 W. Alameda Ave., Suite 303 Burbank, CA 91505. I understand that I am financially responsible for any charges not covered by this assignment. A photostatic copy of this assignment is as valid as the original.

SIGNED: \_\_\_\_\_