Pasadena Women's Medical Group, Inc.
Patient Personal Information – Please Print (Black Ink Only)

Appointment Date_____
Patient's Name (Last)_____(First)_____(Middle)_____
Social Security #_____Date of Birth_____Marital Status_____
Address_____City_____State_____Zip_____
Home # ( )_____Work #( )_____Cell # ( ) _____
Employer_____Occupation_____
Address_____City_____State_____Zip_____
In Case of Emergency, Notify_____Relationship_____
Address_____Phone # ( )_____
E-Mail_____Referred By_____

Primary Insurance Information (If Subscriber is Same as Above, Please Write "Same as Above")

Name (Last)_____(First)_____Date of Birth_____
Social Security #_____Relationship to Patient_____
Address_____City_____State_____Zip_____
Home # ( )_____Work # ( )_____Cell # ( )_____
Employer_____Occupation_____
Address_____City_____State_____Zip_____
Name of Insurance_____Subscriber_____
ID#_____Group#_____Co-Payment/Deductible_____

Secondary Insurance Information

Name (Last)_____(First)_____Date of Birth_____
Social Security #_____Relationship to Patient_____
Address_____City_____State_____Zip_____
Home # ( )_____Work # ( )_____Cell # ( )_____
Employer_____Occupation_____
Address_____City_____State_____Zip_____
Name of Insurance_____Subscriber_____
ID#_____Group#_____Co-Payment/Deductible_____

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmittal of my records, if necessary.
I allow any messages to be left at this phone number_____
I hereby authorize all insurance benefits to be paid directly to *PASADENA WOMEN'S MEDICAL GROUP*. I understand that I am responsible for charges as designated by my insurance companies (e.g., deductibles, co-payments). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Date_____ Signature_____