Temecula Valley OB/GYN
Medical Associates, Inc.
OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT REGISTRATION FORM

Medical Center Drive, Suite 100
Murrieta, CA 92562
(951) 677-4748 FAX (951) 677-2926

NEW PATIENT ☐ UPDATE ☐ Doctor: Account: Date:

PATIENT INFORMATION

Patient Name ______________________ (Last / First / Middle) Age _______ DOB ___________ Sex _____

Address ______________________ City ______________________ Zip ____________

Please indicate, in the boxes below, which order you would like us to contact you (1st, 2nd and 3rd choice)

☐ Home Phone # ______________ ☐ Cell Phone # ______________ ☐ Alternate Phone # ______________

Social Security ______________ Verified ______________ Marital Status ______________

Patient's Employer ______________________ Occupation ______________________

Local Friend or Relative Name ______________ ______________ (Home Phone) ______________ (Work Phone)

This information **MUST** be supplied.

Emergency Contact Other than Husband ______________ (Name) ______________ (Relationship) ______________ (Phone)

Full Address ______________________________________

Primary Care Physician ______________________ Phone ______________

Referred By ______________________ ☐ Family ☐ Friend ☐ Physician ☐ Insurance ☐ Other

PRIMARY INSURANCE INFORMATION

Insurance Co Name ______________________

Subscriber Name ______________________ DOB ___________ Relationship to PT ______________

Identification No ______________________ Group No ______________________

Effective Date ______________________ Social Security # ______________________

Insured Employer ______________________ Work Phone ______________________

SECONDARY INSURANCE INFORMATION

Secondary Insurance Co Name ______________________

Subscriber Name ______________________ DOB ___________ Relationship to PT ______________

Identification No ______________________ Group No ______________________

Effective Date ______________________ Social Security # ______________________

Insured Employer ______________________ Work Phone ______________________

RESPONSIBLE PARTY INFORMATION

Name ______________________ DOB ___________ Age _________

Address ______________________ City ______________________ Zip ____________

Home Phone ______________ Work Phone ______________ Rel to PT ______________ Sex _______

Social Security # ______________________ Driver's License # ______________________

Responsible Party Employer ______________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Temecula Valley OB/GYN Medical Associates, Inc. to examine and treat the above patient and will assume full responsibility for payment of all services. In the event of default, I also agree to pay for collection costs and attorney's fees that may be required to effect collection of the amount. The undersigned hereby authorizes Temecula Valley OB/GYN Medical Associates, Inc. to furnish necessary information to the involved insurance company, and further authorizes and assigns payment and surgical benefits due under the insurance policy.

Responsible Party Signature ______________________ Date ______________________

Relationship to Patient ______________________