Rancho OB/GYN

PERSONALIZED MEDICAL CARE FOR WOMEN

Better Health Starts Here

UPDATED PATIENT INFORMATION

PATIENT INFORMATION (Please complete ALL information) Today's Date: _____

Patient Name:_____ Date of Birth: _____

Street Address: _____City: _____ State: _____ Zip _____

Driver's License # _____ SS # _____

Home Phone: _____ Employer: _____

Work Phone: _____ Occupation: _____

Cell Phone: _____ E-Mail: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Street Address: _____ City: _____ State: _____

INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance: _____

☐HMO ☐PPO ☐POS ☐HSA ☐HMO ☐PPO ☐POS ☐HSA

Insured's Name: _____ Insured's Name: insured

Relationship to Patient: _____ Relationship to Patient: _____

INS #: _____ INS #: ins

Primary Doctor: _____ Primary Doctor's Phone No: _____

25395 Hancock Ave. Suite 210
Murrieta, CA 92562
www.ranchoobgyn.com

Phone: (951) 600-7066
Fax: (951) 600-7783
Email: admin@ranchoobgyn.com

Patient Name: _____

EMERGENCY CONTACT (nearest relative not living with you)

Name: _____ Phone: _____

PAYMENT AGREEMENT FOR SERVICE RENDERED

- I agree to be financially responsible for amounts owed to Rancho OB/GYN; this includes the cost of all deductibles, all non-covered services, all unauthorized procedures performed by Rancho OB/GYN.
- I understand that some insurance carriers do not cover routine exams and preventative care visits, I agree to pay Rancho OB/GYN for the cost of all non-covered services.
- I understand that the cost of services is to be paid at time the services are rendered. I agree to pay all my copayments at the time of the office visit.
- I agree to pay any monies owed directly to Rancho OB/GYN even if I have health insurance and expect to be reimbursed by my insurance company.
- I hereby authorize my insurance company to pay Rancho OB/GYN directly for any services provided to me by their office. This authorization will remain in effect until revoked in writing by the undersigned.
- I hereby authorize Rancho OB/GYN to release any information acquired in the course of my examination/ treatment to my insurance company in order to obtain payment on my behalf.

I agree to be bound by the financial policies of this agreement:

Date: _____

_____
Signature of patient or authorized adult (if patient is a minor)

_____
Name of Parent or Guardian (if patient is a minor)

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