Women's
Health Partnership Medical Group
EXCELLENT CARE FOR EVERY SEASON OF LIFE

TWO CONVENIENT LOCATIONS:
168 North Brent Street, Suite 407
Ventura, CA 93003
(Across from Community Memorial Hospital)
110 West Harvard Boulevard, Suite D
Santa Paula, CA 93060
(805) 648-2717 • www.WomensHealthMedGroup.com

PATIENT'S INFORMATION

Patient's Name _____ Date of Birth _____
First Middle Last

Address _____ Age _____

City _____ State _____ ZIP _____

Phone # _____ Cell Phone # _____

Social Security # _____ Driver's License # _____

Employer _____ Address _____ City _____

Employer's Phone # _____ Date of Employment _____ Occupation _____

Marital Status Single ____ Married ____ Divorced ____ Widowed ____

Spouse's Name _____ Date of Birth _____ Social Security # _____

Spouse's Employer _____ Address _____ City _____

Phone # _____ Date of Employment _____ Occupation _____

Were you referred to us by another doctor? _____ Doctor's Name _____

Were you referred by a friend? _____ Name _____

INSURANCE INFORMATION

Insurance Name _____ Policy # _____ Effective Date _____

Insurance Address _____ City _____ State _____ ZIP _____

Name of policy holder _____ Date of Birth _____ Social Security # _____

Address _____ City _____ ZIP _____

Employer (if not listed above) _____ Phone # _____

Insurance Coverage through work Yes _____ No _____ Date of Employment _____

Relationship to Patient _____

In case of emergency please contact (relative) _____ Phone # _____

(friend) _____ Phone # _____

Assignment and Authorization: I hereby authorize Dr's. Diesfeld & Pattamakom to release any and all medical information to my insurance carrier for purposes of claims, administration and evaluation, utilization and review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization and understand it. I hereby assign to Dr's. Diesfeld & Pattamakom all money to which I am entitled for Obstetric and/or Gynecological expense relative to the service rendered to me, but not to exceed my indebtedness to said physician/surgeon. It is understood any money received from my insurance carrier, over and above my indebetedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. I further agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required.

Signature _____ Date _____