



**Newport Beach OB/GYN Medical Group, Inc.** (use "tab" on keyboard to go from field to field)

**Date:** \_\_\_\_\_

This information is confidential. We appreciate your cooperation in completing this form thoroughly. Please print legibly.

Patient's Name: \_\_\_\_\_  
Last First M

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Driver's License: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

\*\*\*\*\*

Spouse's Name: \_\_\_\_\_

Spouse's Phone Number: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer's Name: \_\_\_\_\_

Spouse's Employer's Phone: \_\_\_\_\_

In case of emergency, nearest friend of relative not living with you:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Phone: \_\_\_\_\_

\*\*If responsible party is other than patient, please complete this section:

Responsible Party: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Emp #: \_\_\_\_\_

Driver's License: \_\_\_\_\_

Social Security #: \_\_\_\_\_

\*\*\*\*\*

**Medical Insurance Information:**

Primary Medical Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Secondary Medical Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Policy Number: \_\_\_\_\_

\*\*\*\*\*

- I authorize and consent to examination and treatment of the above-named patient as deemed necessary by: Ronald L. Pennington, M.D., Patricia E. Korber, M.D., Stephanie Ricci, M.D., Bernard M. Feldman, M.D., Christina J. Lee, M.D. and Staff
- I authorize the release of medical information necessary to process this claim.
- I authorize the payment of medical and/or surgical benefits to physician or supplier.
- I acknowledge that I am responsible for payment of all charges in full

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby authorize treatment for my child, who is under the age of 18, to be treated by Dr. Pennington, Dr. Korber, Dr. Ricci, Dr. Feldman, Dr. Lee, M.D. and Staff

Signed: \_\_\_\_\_

Date: \_\_\_\_\_