CENTER FOR MATERNAL FETAL MEDICINE OF SANTA MONICA

A MEDICAL CORPORATION

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Tel: (310) 393-7147
Fax: (310) 451-6286

PATIENT NAME ______________________________ ____ **CELL PHONE** ____________________
Last First MI Area Code Number

ADDRESS ______________________________ **PHONE** ____________________
Number Street Unit/Apt Area Code Number

CITY ______________________ **STATE** __________ **ZIP** ____________

SOCIAL SECURITY NUMBER ____________________ **DRIVER'S LICENSE NUMBER & STATE** ____________

BIRTHPLACE ______________________ **BIRTHDATE** _____/ _____/ _______ **AGE**__________
City State/Country Mo Day Year

EMPLOYER ______________________ **OCCUPATION** ______________________

EMPLOYER'S ADDRESS______________________________ **PHONE** ____________________
Number Street City State Zip Area Code Number Ext

RELIGION (OPTIONAL) __________ **MARRIED** ____ **SINGLE** ____ **WIDOWED** ___ **DIVORCED**___ **SEPARATED**___

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SPOUSE OR RESP PARTY NAME ______________________________ **BIRTHDATE** ____________________
Last First Mo Day Year

EMPLOYER ______________________ **OCCUPATION** ______________________

EMPLOYER'S ADDRESS ______________________________ **PHONE** ____________________
Number Street City Zip

RELATIONSHIP ______________________ **SOCIAL SECURITY NUMBER** ____________________

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PATIENT REFERRED BY ______________________ **PHONE** ______________________

NAME OF NEAREST RELATIVE OR FRIEND, OTHER THAN ABOVE, IN CASE OF EMERGENCY

NAME ______________________ **RELATIONSHIP** ______________________

ADDRESS ______________________________ **PHONE** ____________________
Number Street City Zip Area Code Number

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INSURANCE INFORMATION

PRIMARY CARRIER ______________________ **SUBSCRIBER NAME** ____________________
CERTIFICATE # ______________ **GRP #** __________**EFFECTIVE DATE** ____________________

SECONDARY CARRIER ______________________ **SUBSCRIBER NAME** ____________________
CERTIFICATE # ______________ **GRP #** __________**EFFECTIVE DATE** ____________________

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AUTHORIZATION AND ASSIGNMENT

I hereby authorize Center for Maternal Fetal Medicine of Santa Monica to furnish to my insurance company all information which they may request concerning my illness and treatment.
I hereby assign to Center for Maternal Fetal Medicine of Santa Monica all insurance payments to which I am entitled for medical and/or surgical services rendered to me. I understand that I am financially responsible for all fees, regardless of insurance coverage and/or benefits. A copy of this assignment is as valid as the original.

Patient's Signature ______________________________ **DATE** __________