West Coast Ob/Gyn, Inc.

☐ 7695 Cardinal Court,
Suite 240
San Diego, CA 92123

☐ 8860 Center Drive,
Suite 360
La Mesa, CA 91942

☐ 6125 Paseo Del Norte,
Suite 200
Carlsbad, CA 92011

Patient Registration

Patient's Name:_____
LAST FIRST MIDDLE

Home Address:_____
Number & street apt city state zip

Number you would like Doctor to call you with results:_____

Cell Phone:_____ Date of Birth:_____ Social Sec#_____

Marital Status: M W S D Driver's Lic#:_____ E-mail:_____

Employer:_____ Occupation:_____

Employer Address:_____
Number & street suite city state zip

Your visit today only includes time spent w/the provider.
All labs, specimens or pathology are not included & will be billed from an outside vendor.
I understand that I am financially responsible for all charges not covered by my insurance.
Please initial_____

Emergency Contact

1. Name:_____ Phone Number:_____
2. Name:_____ Phone Number:_____

Please provide the Front Desk with a copy of your insurance card/ information

How were you referred to our office?_____

Assignment/Authorization

I hereby authorize payment of insurance benefits to be made to West Coast Ob/Gyn, Inc. for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by my insurance. In the even of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize the release of any medical information necessary to process my insurance claims. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.

Signature:_____ **Date:**_____