



Escondido OB-GYN Medical Group, Inc. dba

# NORTH COUNTY WOMEN'S SPECIALISTS

488 East Valley Parkway, Suite 310, Escondido, CA 92025

## PATIENT REGISTRATION

### **PATIENT INFORMATION**

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_  
Address: \_\_\_\_\_ Marital Status \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### EMERGENCY CONTACT

Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone # \_\_\_\_\_  
Relationship: \_\_\_\_\_

### **INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### **RESPONSIBLE PARTY INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
SSN #: \_\_\_\_\_ Address: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS & PAYMENTS OF ACCOUNT

I authorize Escondido OBGYN/North County Women's Specialists to release medical information for insurance purposes concerning treatment of the above-named patient, while under their care. I authorize payment of any Insurance Benefits for medical or surgical directly to Escondido OBGYN/North County Women's Specialists. I agree to pay any fees not covered by the Insurance Benefits directly to, Escondido OBGYN/North County Women's Specialists. If my account is forward to a collection agency, I agree to pay all collection fees.

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

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