Patient Information & Demographics

Last Name:_____First Name:_____

Date of Birth:_____/_____/_____ Age:_____

Mailing Address:_____

City_____State_____ZipCode_____

Home Phone :_____ Work Phone:_____

Cell Phone:_____ Email:_____

Preferred Contact Method: ❑Home ❑Work ❑Cell ❑Email

Employer:_____ Marital Status: (S) (M) (D) (W)

Emergency Contact Name:_____ Phone:_____

Referred by_____

Insurance Information

Primay Ins Co: _____ Name of Insured:_____

ID Number: _____ Group Number: _____Date Of Birth:_____

Secondary Ins Co: _____ Name of Insured:_____

ID Number: _____ Group Number: _____Date Of Birth:_____

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the Medical Board of California
(800)633-2322
www.mbc.ca.gov

I understand Santa Barbara OB/GYN Medical Center is OPT-OUT of Medicare and an OUT OF NETWORK PROVIDER for all insurance companies except CoreSource and that payment is due in full at them of service. Methods of payment accepted are cash, personal check, Mastercard, Visa or Discover. I alsounderstand that as a courtesy to me, my insurance will be billed, any and all reimbursements will come directly to me, and I need to contact my insurer for any questions I may have.

Date:_____/_____/_____ Signature:_____