

**Jeffrey P. Block M.D., F.A.C.O.G.**

A Professional Corporation

2220 Lynn Road Suite 302

Thousand Oaks, CA 91360

**PATIENT INFORMATION**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Who referred you to us? \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex M / F \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone# ( ) \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_ Cell Phone# ( ) \_\_\_\_\_

Social Security# \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status (circle one) Single Married Divorced Widowed

Employer \_\_\_\_\_ Address \_\_\_\_\_

Patient's Occupation \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse Employer \_\_\_\_\_ Address \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Spouse Work Phone# ( ) \_\_\_\_\_ Spouse Cell Phone# ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

Reason for Office Visit \_\_\_\_\_

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**Primary Insurance** \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Claim Form Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_ Phone#( ) \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

**I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges and non-covered medical services.**

**I hereby authorize the release of any medical information necessary for the process of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Jeffrey P. Block M.D., a Professional Corporation. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I have received the Notice of Privacy Practices.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_