Coast OB-GYN
DR. HIND AL-AZAWI

Coast OB-GYN
366 San Miguel Dr. #209
Newport Beach, CA 92660
Phone: 949-520-7078 Fax: 949-209 4177

PATIENT INFORMATION

NAME (Last, First, Middle)	SSN#	BIRTHDATE

MAILING ADDRESS	CITY, STATE, ZIP	FAX (If Private)

HOME PHONE	CELL PHONE	EMAIL ADDRESS (If Private)

MARITAL STATUS: M D W S ☐ ☐ ☐ ☐	REFERRED BY:	FORMER NAME (MAIDEN)

SPOUSE'S NAME	WORK PHONE	CELL PHONE

EMPLOYER	CLOSEST RELATIVE'S NAME:

ADDRESS	ADDRESS

CITY, STATE, ZIP	CITY, STATE, ZIP

WORK PHONE	PHONE	RELATIONSHIP

INSURANCE COMPANY INFORMATION

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

PATIENT'S RELATIONSHIP TO INSURED PARTY: ☐ SELF ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ PARENT ☐ OTHER_____

*IF NOT SELF, PLEASE LIST INFORMATION FOR THE RESPONSIBLE PARTY
NAME:

MAILING ADDRESS:	CITY, STATE, ZIP

HOME PHONE:	CELL PHONE:

PLACE OF WORK:	WORK PHONE:

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#

NAME OF INSURED		GROUP#

ADDRESS OF INSURANCE COMPANY		COPAY AMT

CITY, STATE, ZIP	PHONE	EFFECTIVE DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		POLICY#

NAME OF INSURED		GROUP#

ADDRESS OF INSURANCE COMPANY		COPAY AMT

CITY, STATE, ZIP	PHONE	EFFECTIVE DATE

I authorize any holder of medical or other information about me to release this information to the Social Security Administration, Health Care Financing Administration, my insurance company or it's intermediaries or carriers, or to this physician's office or my attorney or other doctor's office. **While we will assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral, and/or the payment of your bill**.

I authorize direct payment of medical benefits, and or surgical benefits to Coast OB-GYN. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Date: _____ Patient Signature: _____

Guardian Signature: _____