Center for Fetal Medicine and Women's Ultrasound

6310 San Vicente Blvd. | Suite 520 | Los Angeles, CA 90047
Tel: 323-857-1982 | Fax: 323-857-5336

PATIENT REGISTRATION FORM

Physician			☐ New Pt ☐ Update	☐ Cash ☐ PPO
Patient Name			DOB	
Address		City	State & ZIP	
Spouse / Partner Name				
Emergency Contact		Tel	Relationship	

To respect your privacy, please check your preferred method of communication regarding appointment reminders, lab results, etc.

☐ Home Telephone	☐ Work Telephone	☐ Cell Telephone	☐ Email:

Referring Physician	
Drug Allergies ☐ None	
Have you been here using another name?	☐ Yes ☐ No If **YES**, please list other name(s)

☐ I understand that I am responsible for charges, deductibles, and appropriate co-payments at the time of service unless other arrangements have been made with the billing office.

☐ I authorize payment of medical benefits to be made directly to the Center for Fetal Medicine and Women's Ultrasound for services rendered and I am responsible for any payment and non-covered service.

☐ I hereby authorize the Physician to release any information necessary acquired in the course of my treatment to process insurance claims. I understand by not supplying my complete insurance information, I will be responsible for my account balance.

Signature	Date