ADVANCED OB/GYN SLO CITY MIDWIVES

PATRICK J. SPALDING M.D.

REGISTRATION FORM

TODAY'S DATE: _____YOUR BIRTHDATE: _____

PATIENT_____
LAST FIRST MIDDLE

MARITAL STATUS_____ MAIDEN NAME_____

MAILING ADDRESS_____
STREET CITY STATE ZIP CODE

CELL PHONE _____HOME PHONE_____ SSN_____

EMAIL ADDRESS_____MAY WE TEXT YOU?__Y/N___

PRIMARY INS_____SECONDARY INS_____

EMPLOYER_____ EMPLOYER PHONE#_____

EMPLOYERS ADDRESS_____ OCCUPATION_____

*SPOUSE*_____ *SPOUSE'S EMPLOYER*_____

*SPOUSE'S OCCUPATION*_____ *PHONE #*_____

*SPOUSE'S SOCIAL SECURITY #*_____ *DATE OF BIRTH*_____

REFERRED BY:_____

IF YOU ARE A MINOR, GIVE PARENTS NAME AND ADDRESS:

_____

NAME & ADDRESS OF EMERGENCY CONTACT (OTHER THAN SPOUSE):

_____
NAME ADDRESS CITY, STATE, ZIP PHONE NUMBER

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I HEARBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO PATRICK J. SPALDING M.D., AND/OR SLO CITY MIDWIVES, AND ANY ASSISTING PHYSICIANS, FOR SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION, AND REASONABLE ATTORNEY'S FEES. I HEARBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

DATE_____YOUR SIGNATURE_____