Edward C. Spoon Jr., M.D., FACS, FACOG
Las Vegas OB/GYN Women's Care
401 N. Buffalo Drive, Suite 110
Las Vegas, NV 89145
(702)778-4000 Fax (702)778-4001

Date:_____ **Referred by:**_____

Patient's Name:_____
Address:_____Apt# _____
City:_____State:_____Zip:_____ Email _____
Home Phone:( )_____Busn. Phone( )_____Cell Phone:( )_____
Patient Gender:_____Date of birth:_____/_____/_____Age:_____Social Security #_____-_____-_____

Marital Status: Single Married Separated Divorced Widowed

Patients Employer:_____
Employer Address:_____
City:_____State:_____Zip:_____
Occupation:_____Drivers License #:_____

Financially Responsible (Spouse/Parent)_____Relationship:_____
Address:_____
Date of Birth:_____/_____/_____ Employer:_____
Address:_____
Business Phone( )_____Social Security #_____-_____-_____Drivers License #_____

Nearest Friend/Relative not living with you:_____
Relationship to Patient:_____Phone ( )_____
Address:_____City:_____State:_____Zip:_____

Primary Ins:_____
Insured:_____
Policy #_____
Group #_____
Address:_____
City:_____**State:**_____**Zip:**_____

Secondary Ins:_____
Insured:_____
Policy #_____
Group #_____
Address:_____
City:_____**State:**_____**Zip:**_____

ASSIGNMENT OF BENEFITS

I hereby guarantee payment of all charges incurred for patient _____. I also hereby assign and direct any surgical or medical benefits under this claim to Edward C. Spoon Jr., M.D**.** I also hereby authorize the **Business Manager and/or Dr. Spoon** to furnish information requested by the insurance companies in connection with the above assignment. I agree to pay all unpaid charges if claim is paid out of network. In the event my insurance company does not pay for services rendered within 90-day of date of service, I understand I will be responsible for payment in full to my physician.

Signature_____ **Date**_____