Specialty Obstetrics of San Diego
3750 Convoy Street, Suite 200
San Diego, CA 92111

PATIENT REGISTRATION

DATE ____/____/____

NAME _____ DOB ____/____/_____
First *Middle* *Last*

MAIDEN NAME _____

MAILING ADDRESS_____
Street/P.O. Box *Apt #* *City* *State* *Zip Code*

PHONE _____ ALT PHONE _____ E-MAIL _____

PATIENT'S OCCUPATION _____ EMPLOYED BY _____

SOCIAL SECURITY ____-____-____

RACE:	ETHNICITY:
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER	☐ HISPANIC / LATINO ☐ NON-HISPANIC / LATINO NATIONALITY: _____ PRIMARY LANGUAGE: _____

NAME OF PARTNER_____ ____/____/_____
First *Middle* *Last* *DOB*

PARTNER'S OCCUPATION _____ EMPLOYED BY _____

SOCIAL SECURITY _____-_____-_____ **(FOR TRICARE INSURANCE ONLY)**

EMERGENCY CONTACT _____
RELATIONSHIP _____ PHONE _____

REFERRING DOCTOR _____
HOW DID YOU HEAR ABOUT US? _____

PREFERRED PHARMACY _____ PHONE _____

***** Please complete this entire form, if possible. This information will be used not only for registration information, but also for patient check-in and billing purposes. Thank you very much for your time. *****

PATIENT INSURANCE

INSURANCE: YES [ ] NO [ ]

INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____

RELATIONSHIP TO SUBSCRIBER:

- SELF
- SPOUSE
- DEPENDENT

MEMBERSHIP # _____ GROUP # _____

ADDRESS _____

P.O. Box/Street *City* *State* *Zip Code*

_____

SECONDARY INSURANCE: YES [ ] NO [ ]

SECONDARY INSURANCE COMPANY: _____

SUSCRIBER NAME: _____

RELATIONSHIP TO SUBSCRIBER:

- SELF
- SPOUSE
- DEPENDENT

MEMBERSHIP # _____ GROUP # _____

ADDRESS _____

P.O. Box/Street *City* *State* *Zip Code*

I authorize the release of any medical information necessary to process medical insurance claims for services rendered. I authorize and request medical insurance benefits to be paid directly to Specialty Obstetrics of San Diego.

SIGNED_____ DATE ____/_____/____

***** Please complete this entire form, if possible. This information will be used not only for registration information, but also for patient check-in and billing purposes. Thank you very much for your time. *****

PATIENT FINANCIAL RESPONSIBILITY

It is the patient's responsibility to provide up-to-date information regarding insurance, name, address and telephone changes. Please provide changes to the front desk prior to any visit or test. It is the responsibility of the patient to inquire with their insurance to be certain that the providers at Specialty Obstetrics of San Diego are participating in their health plan.

Co-Pay and Deductible:

You are responsible for your co-pay on the day service is rendered. If you have a health plan, as a courtesy we will send a claim to them for service rendered. No discounts will be given for Co-pay, co-insurance and deductibles.

Initial: _____

Non-Covered Services:

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes agreement to pay for such services.

Initial: _____

Self Pay/No Insurance:

Payment in full is expected on the day service is rendered.

Payment Arrangements and Payment Plans:

Payment may be made with cash, check, Visa, MasterCard or American Express. Payment Plans must be made with the billing department in advance.

Service Charge Fees:

A service charge fee will be applied to your account for the following reasons:

1. $30.00 fee charged for all missed appointments or cancellations unless notice is received a minimum of 24 hours in advance

2. $25.00 fee charged for return checks. When a second returned check occurs, the patient will be responsible for three (3) times the amount of the check or $100.00, whichever is more.

X _____ Please place your initials here after reading above

Collections:

If it is necessary to assign your account to a collection agency, you will be responsible for all of our collection agency fees and costs. In addition, we will dismiss you from the medical practice. We are happy to discuss with you any questions relating to the information above. We thank you for choosing Specialty Obstetrics of San Diego. We are proud to be your physicians.

Patient Signature: _____ Date: _____

Patient Name: _____

NOTICE TO CONSUMERS

Title 16, California Code of Regulations, section 1355.4 is to inform consumers where to go for information or with a complaint about California medical doctors.

Medical doctors, including Dr. David Dowling, Dr. Yvonne Gollin, Dr. Jennifer Ahn, and Dr. Michelle Nguyen are licensed and regulated by the Medical Board of California.

For Information, please call: (800) 633-2322

Or visit their website: www.mbc.ca.gov

Patient Signature: _____ Date: ____/____/_____

Patient Name: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review out Notice before signing this form. As provides in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by this agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature: _____ Date: ____/____/_____

Patient Name: _____