

Richard Bardowell, M.D.
Obstetrics • Gynecology • Infertility

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PATIENT INFORMATION SHEET

DATE: _____
PATIENT'S NAME: _____ BIRTHDATE: _____ AGE: _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL PHONE: _____ BIRTHPLACE: _____
EMAIL: _____ RELIGION: _____
MARITAL STATUS: _____ MAIDEN NAME: _____ SOC. SECURITY #: _____
OCCUPATION: _____ EMPLOYER: _____
BUS. ADDRESS: _____ CITY: _____ ZIP: _____
BUS. PHONE: _____ HOW LONG: _____ DRIVER'S LICENSE NO: _____

SPOUSE'S NAME: _____ SOC. SECURITY #: _____ BIRTHDATE: _____ AGE: _____

(If patient is a minor, name of responsible parent or guardian)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ BIRTHPLACE: _____ RELIGION: _____
OCCUPATION: _____ EMPLOYER: _____
BUS. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
BUS. PHONE: _____ HOW LONG: _____ DRIVER'S LICENSE: _____

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN SPOUSE)

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE: _____

PATIENT REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ POLICYHOLDER: _____
CERTIFICATE NO: _____ GROUP NO: _____
INSURANCE ADDRESS: _____ PHONE: _____
SECONDARY INSURANCE: _____ POLICYHOLDER: _____
CERTIFICATE NO: _____ GROUP NO: _____
INSURANCE ADDRESS: _____ PHONE: _____

ASSIGNMENT OF BENEFITS

I hereby authorize _____ to pay for surgical and/or medical benefits directly to RICHARD BARDOWELL, M.D. 2701 W. Alameda Ave., Suite 604 Burbank, CA 91505. I understand that I am financially responsible for any charges not covered by this assignment. A photostatic copy of this assignment is as valid as the original.

SIGNED: _____