

**Western OB/GYN**

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**GUARANTOR:**

Name:  
Address:

**SPOUSE**

Name:  
Marital Status:

Home Phone:  
Work Phone:

Home Phone:  
Employer:  
Work Phone:

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**PATIENT NAME:**

Patient Address:

Social Security #:  
Date of Birth:  
Relationship to Guarantor:  
Living Will ?  
Other Name:

**INSURANCE:**

Primary:  
Group #:  
Policy #:  
Policy Holder:

Secondary:  
Group #:  
Policy #:  
Policy Holder:

**PATIENT EMPLOYER:**

Name:  
Employer address:  
  
Employer phone #

**PATIENT NEXT OF KIN:**

Name:  
Relation to patient:  
Home phone #:  
Work phone #:

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I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO RIDGEVIEW RESEARCH: \_\_\_ YES \_\_\_ NO. I AUTHORIZE WESTERN TO RELEASE INFORMATION TO MY INSURANCE TO APPROVE/PROCESS CLAIMS AND TO REFERRAL PROVIDERS. I ASSIGN BENEFITS TO BE PAID TO WESTERN AND ACCEPT FINANCIAL RESPONSABILITY FOR PAYMENT NOT MADE BY INSURANCE. I UNDERSTAND THAT IF WESTERN NEEDS TO CONTACT ME VIA TELEPHONE, THEY MAY LEAVE A MESSAGE ON MY ANSWERING MACHINE OR VOICEMAIL.

I AUTHORIZE \_\_\_\_\_ THE AUTHORITY TO DISCUSS MY MEDICAL CARE/TEST RESULTS FROM \_\_\_/\_\_\_/\_\_\_ TO \_\_\_/\_\_\_/\_\_\_ - NOT TO EXCEED ONE YEAR.

SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_