UCLA Health

THOUSAND OAKS
PATIENT INFORMATION

Name: _____ **Marital Status: S - M - D - W**
Last Name First Name Middle Initial

Ethnicity & Race: _____ **Birth State:** _____ **Religion:** _____

How would you like to be addressed by our staff? _____

Address: _____
Street

_____
City State Zip

Mailing Address: ☐ **As above**

_____
Street

_____
City State Zip

E-Mail : _____

Phone: _____ *Home*

_____ *Work*

_____ *Cell*

Occupation: _____

Employer: _____

Employer's Address: _____

_____

Social Security #: _____

Date of Birth: _____

Primary Care Physician: _____

Person To Contact In Case of Emergency

Name: _____

Relationship: _____

Phone: _____

Preferred Pharmacy Information:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Primary Insurance Company Name & Phone #: _____

Address: _____

Name of Policy Holder: _____ **DOB:** _____

Certificate/ID #: _____ **Group:** _____

Secondary Insurance Company Name & Phone #: _____

Address: _____ **DOB:** _____

Name of Policy Holder: _____

Certificate/ID #: _____ **Group:** _____

I have insurance coverage and assign directly to UC Regents all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

_____ _____
Signature of Patient, Parent or Guardian Date