UCLA Health System

Westlake Village Medical Group

PATIENT INFORMATION

Date:_____ UCLA ID #:_____

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

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 address:_____

Phone:_____ *Home*

_____ *Work*

_____ *Cell*

Occupation:_____

Employer:_____

Employer's Address:_____

Social Security #:_____

Date of Birth:_____

Name of Spouse:_____

Referred By:_____

Person To Contact In Case of Emergency

Name:_____

Relationship:_____

Phone:_____

Nearest Relative/Friend Not Living With You

Name:_____

Relationship:_____

Phone:_____

Primary Insurance Company Name & Phone #:_____

Address:_____
Street City State Zip

Name of Policy Holder:_____

Certificate/ID #:_____ Group:_____

Secondary Insurance Company Name & Phone #:_____

Address:_____
Street City State Zip

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