Fertility & Surgical ASSOCIATES OF CALIFORNIA

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PATIENT INSURANCE INFORMATION FORM

PATIENT'S INFORMATION **FSMAC #:** _____ (For Office Use Only) **LA - VENTURA SURG. CENTER #:** _____ (For Office Use Only)

FIRST NAME: _____ **MI:** _____ **LAST:** _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

INSURED'S EMPLOYER: _____ **RELATIONSHIP TO PATIENT:** _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

INSURED'S EMPLOYER: _____ **RELATIONSHIP TO PATIENT:** _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

PARTNER'S INFORMATION

If different from above

FSMAC #: _____ (For Office Use Only) **LA - VENTURA SURG. CENTER #:** _____ (For Office Use Only)

FIRST NAME: _____ **MI:** _____ **LAST:** _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

INSURED'S EMPLOYER: _____ **RELATIONSHIP TO PATIENT:** _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

INSURED'S EMPLOYER: _____ **RELATIONSHIP TO PATIENT:** _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____