ADVANCED GYNECOLOGY SOLUTIONS, INC.
STEVEN A. RABIN, M.D., F.A.C.O.G.

2701 W ALAMEDA AVE, SUITE 303
BURBANK, CA 91505
818-843-8700

PATIENT INFORMATION

___________________________________ _________________________ ________________________

Patient's Last Name **First** **Middle** Marital Status (circle one)

Single/ **M**arried / **D**iv / **S**ep / **W**id

Birthdate: **SS#:** **Age**:

Street Address: **Apt**:

City: **State**: **Zip Code**:

(☑Check YOUR PREFERRED NUMBER):

Phone # Home: ☐ Cell: ☐ Work:

EMAIL ADDRESS: ____

Emergency Contact : Name: ______________________Phone:______________________ Relationship to you:______________

Dr. Rabin sends occasional emails about upcoming lectures, videos, & recommended health products. We will not sell or share your address.

☑ Do you identify yourself as:

☐ Caucasian /☐ African-American/☐ Asian/Indian/☐ Alask/Pac Islander./ ☐ Other/ ☐ Hispanic/ ☐ **Decline**

How did you hear about Dr. Rabin? □Internet □Insurance Provider List □Friend □Attended Lecture □Hospital Referral □Physician Referral **Who may we thank for referring you?**____

Primary Care Doctor?:_________________________________ **In what City?**___________________________

Occupation/Employer

Business Address

INSURANCE INFORMATION:

Name of Primary Insurance: ____

Subscriber's Name: ____________________________ Subscriber's SS#:___________________ Birthdate: _________

Group #: _________________ Member ID#: ____________________________ Specialist Co-pay: ______________

Patient's Relationship to Subscriber: ○ self ○ spouse ○ child ○ other

Name of Secondary Insurance: (if applicable)____

Subscriber's Name:_____________________________SS#:________________Birthdate:___________

Group#:__________________Member ID#:__________________

Patient's Relationship to Subscriber : ○ self ○ spouse ○ child ○ other

Insurance Card and INFORMATION

PLEASE BRING INSURANCE CARD AND CO-PAYMENT IN TO EVERY VISIT OR IT MAY BE NECESSARY TO RESCHEDULE.

DISCLOSURE STATEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Gynecology Solutions, Inc or the insurance company to release any information required to process my claims. I've had an opportunity to review the HIPPA policy and have my questions answered.

Patient/ Guardian **Signature**: ***X***____ Date: ***X*** _________________