## Pacific Obstetrics & Gynecology CHRISTINA J. LEE, MD JENNIFER C. LEE, MD

## **DEMOGRAPHICS INFORMATION**

All your information remains confidential. We appreciate your cooperation in completing this form.

		Today's Date	
Patient's Name		Date of Birth	Age
Last	First	M	
Address		Driver's License No	
		Social Security No	
Home Phone No.		Occupation	
Cell No		Employer's Name	
Email Address		Employer's Phone	
Spouse/significant other's (SO) Name			
Spouse/SO's DOB		Spouse/SO's SSN	
Spouse/SO's Employer		Spouse/SO's Employer's Phone	
In case of emergency, nearest friend or re	elative not living	with you:	
Name		Relationship to Patient	
Phone No		- -	
If responsible party is other than patient	, please complete	section below:	
Responsible Party			
Address			
		0 110 4 37	
Phone No			
Employer Phone No			
Medical Insurance Information			
Primary Medical Insurance Company		Ef	fective Date
Type of Insurance HMO PP		Subscriber	
If HMO, name of medical group & hospit			
Address		Policy No.	
/ tdd1c55		Phone No.	
Secondary Medical Insurance Company			ffective Date
Type of Insurance HMO PP		Subscriber	
If HMO, name of medical group & hospit		Subscriber	
		Doligy No.	
Address			
		Phone No	
I authorize and consent to an examinat	ion and treatmen	t(s) by the staff and physicians	at Pacific Obstetrics &
Gynecology.			
Signature		Date	
Printed Name			
I hereby authorize the staff and physicia child.	ans at Pacific Obs	tetrics & Gynecology to exami	ne and treat my minor
Signature		Date	
ignature		Polationship to shild	