

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

3808 W. Riverside #503  
BURBANK, CA 91505  
818-843-8700

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Marital Status (circle one)  
Single/ Married / Div / Sep / Wid

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** \_\_\_\_\_