HERA MEDICAL GROUP
1552 Coffee Road, Modesto, Ca. 95355
(209) 521-4372 Fax (209) 523-2005 office@heraobgyn.com

Patient Information:

Patient's Name ______ Date of Birth ______ Social Security Number ______

Mailing Address ______ City ______ State ______ Zip Code ______

E-Mail Address ______ Drivers License Number ______ Primary Language ______ Race/Ethnicity ______

Home Phone # ______ Cell Phone #/Carrier ______ Work Phone # ______ email/text reminders? ______

Patient's Employer ______ Employer Address ______

Parent **OR** Spouse Name ______ Date of Birth ______ Social Security Number ______

Parent **OR** Spouse's Employer ______ Employer Address ______ Work Phone Number ______

Referred By: Physician Name ______ Address ______ Phone ______

Emergency Contact: (Please DO NOT include your spouse)

Name ______ Relationship ______ Phone Number ______

Name ______ Relationship ______ Phone Number ______

Insurance Information:

Primary Insurance ______ ID# ______ Date of Birth ______

Subscriber Name ______ Relationship to Patient ______ Social Security Number ______

Secondary Insurance ______ ID# ______ Date of Birth ______

Subscriber Name ______ Relationship to Patient ______ Social Security Number ______

Assignment of Benefits/Financial Agreement

All professional services rendered are charged to the patient. The necessary forms will be completed by our business office and forwarded to your insurance carrier for payment. The patient is responsible for all fees regardless of insurance coverage. Medi-Cal insurance is not accepted in our office. It is customary to pay for all services at the time services are rendered unless other arrangements have been made in advance. I hereby authorize the above named physician to furnish information to my insurance carrier concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or for my dependents. I understand that I am responsible for the payment of any amount not covered by my insurance. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature of Patient ______ **Date** ______

Signature of Parent or Guardian ______ **Date** ______