



Loma Vista Endocrinology, Inc.

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Name _____ Preferred Language _____ Date _____
Address _____ City _____ State _____ Zip _____
DOB _____ SSN _____ Ethnicity _____ Marital Status _____
Gender Assigned at Birth _____ Preferred Pronoun (circle) He She They Other
Cell Phone _____ Other Phone _____
Email _____
Emergency Contact _____ Phone _____ Relationship _____

Patient or parent's employer _____ Work phone _____
Address _____ City _____ State _____ Zip _____

Primary Care Provider _____ City _____

Responsible Party

Name of person responsible _____ Relationship to patient _____
Address _____ Phone _____ DOB _____
SSN _____ Driver's License# _____

Primary Insurance Information

Name of Insurance _____
Subscriber Name _____
Relationship to patient _____
Subscriber DOB _____
Certificate or ID# _____
Group# _____

Secondary Insurance Information

Name of Insurance _____
Subscriber Name _____
Relationship to patient _____
Subscriber DOB _____
Certificate or ID# _____
Group# _____

Consent of Treatment : I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of any physician who examines and treats me. You are authorized to furnish a copy of this report to my insurance carrier. **Financial Agreement, Assignment of Benefits** : I agree to pay all fees and copayments for services not covered by my medical plan. It is agreed that payments not be delayed or withheld because of any Insurance coverage or the pendency of claims thereon. **Authorization and Assignment**: I hereby authorize agents of Loma Vista Endocrinology to furnish information to insurance carriers or to 3rd party review organization carriers concerning my illness treatments and I hereby assign to the doctor all payments for medical services rendered.

Patient's Signature _____ **Date** _____
Print Name _____ **Relationship to patient if minor** _____