WOMEN'S OB/GYN

INFORMATION REGARDING THE PATIENT

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ SSN# _____ Marital Status (Circle Marital Status) S M D W Sep

Address _____ City, State, Zip _____

Preferred? Preferred?

Home Phone _(____)_____ ☐ OK to leave message Cell Phone _(____)_____ ☐ OK to leave message

EMAIL _____ Employer _____ Work Phone (____)_____

Spouse Name _____ Cell Phone ___(_____)_____

Emergency Contact (Other than spouse) _____

Primary Care Physician _____ PCP Phone __(_____)_____

Pharmacy_____ Pharmacy Phone ___(_____)_____

PERSON RESPONSIBLE FOR PAYMENT AFTER INSURANCE, IF NOT PATIENT

Name _____ Relationship to the patient _____

Billing address _____

ANY INSURANCE REFERRALS/AUTHORIZATION NUMBERS ARE THE RESPONSIBILITY OF THE PATIENT BEFORE THE TIME OF SERVICE

INSURANCE INFORMATION

(In order for your insurance to be billed, please complete this section AND present insurance cards at check-in)

Primary Insurance_____ ID#_____ Group # _____

Whose Name is Insurance Under?_____ Date of Birth _____

Secondary Insurance _____ ID#_____ Group #_____

Whose Name is Insurance Under?_____ Date of Birth _____

I hereby authorize Women's OB/GYN to furnish information concerning my illness and treatments to insurance carriers, other physicians/health care personnel and my spouse. I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I also agree to pay all attorney and collection fees associated with the collection of fees for any services rendered. I understand that I am responsible for any amount incurred.

Signature _____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for Women's OB/GYN; and I understand that I may contact the office if I have questions about the content of the Notice.

I give authorization to speak to the following people regarding my care: _____

Signature of patient or parent/legal guardian_____

Date_____