

Thank you for choosing OB/GYN Associates! **PLEASE PRINT.** All information will be confidential.

**PATIENT**

**RESPONSIBLE PARTY** (if different than patient)

Name Last, First \_\_\_\_\_

Name Last, First \_\_\_\_\_

Mailing Address \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Cell # \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ Cell # \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Status:  Single  Married  Divorced  Widowed  Other

Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_

Patient's Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Emergency contact \_\_\_\_\_ # \_\_\_\_\_

Student? If yes, name of school \_\_\_\_\_

Patient Email Address \_\_\_\_\_

**Primary Insurance**

**Secondary Insurance**

Name of Insurance \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

Name of policyholder \_\_\_\_\_

Name of Policyholder \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_

Policyholder's Employer \_\_\_\_\_

Policy # \_\_\_\_\_ Group \_\_\_\_\_

Policy# \_\_\_\_\_ Group \_\_\_\_\_

Patient relationship to policyholder \_\_\_\_\_

Patient relationship to policyholder \_\_\_\_\_

Policy Holder \_\_\_\_\_ Male \_\_\_\_\_ Female

Policy Holder \_\_\_\_\_ Male \_\_\_\_\_ Female

Policy Holder's DOB \_\_\_\_\_

Policy Holder's DOB \_\_\_\_\_

Effective Date of Insurance \_\_\_\_\_

Effective Date of Insurance \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-Ins \_\_\_\_\_ % or Co-pay \$ \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-pay \$ or % \_\_\_\_\_

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating & administering claims for insurance benefits. I authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also agree that I will be responsible for payment of charges, regardless of payment or denial of payment from my insurance company, including charges deemed non-covered.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Acct # \_\_\_\_\_