PARTNERS *in* OBSTETRICS *and* GYNECOLOGY

PATIENT INFORMATION

FIRST NAME MIDDLE INITIAL LAST			PREVIOUS NAME	AGE	DATE OF BIRTH
STREET ADDRESS			GENDER: ❑ FEMALE ❑ MALE		
CITY	STATE	ZIP CODE	RACE: ❑ AM INDIAN ❑ HAWAIIAN/PACIFIC ISLANDER ❑ AFRICAN AMERICAN ❑ CAUCASIAN ❑ OTHER		
HOME PHONE	CELL PHONE		ETHNICITY: ❑ HISPANIC OR LATINO ❑ NON-HISPANIC OR LATINO		
SOCIAL SECURITY			ALLERGIES: ❑ NO ❑ YES, PLEASE LIST		
E-MAIL			PREFERRED LANGUAGE		
NAME YOU LIKE TO USE			EMPLOYER WORK PHONE		

SPOUSE / PARENT INFORMATION

NAME OF SPOUSE/PARENT	EMERGENCY CONTACT	
ADDRESS (IF DIFFERENT FROM ABOVE)	RELATIONSHIP HOME TELEPHONE	WORK TELEPHONE
REFERRED BY		

INSURANCE INFORMATION

PLEASE HAVE INSURANCE CARD READY FOR RECEPTIONIST TO COPY

PRIMARY INSURANCE COMPANY NAME AND ADDRESS		POLICY HOLDER NAME POLICY HOLDER ADDRESS		
POLICY ID NUMBER GROUP NUMBER		DATE OF BIRTH	SOCIAL SECURITY	HOME PHONE
SECONDARY INSURANCE COMPANY NAME AND ADDRESS		POLICY HOLDER NAME POLICY HOLDER ADDRESS		
POLICY ID NUMBER	GROUP NUMBER	DATE OF BIRTH	SOCIAL SECURITY	HOME PHONE
NAME OF FAMILY / REFERRING DOCTOR		DATE		

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay the physician his/her usual charges for services, including any balance not covered by my insurance carrier.

RECORDS FOR RELEASE FOR CLAIMS PAYMENTS

I authorize the release of any medical or other information to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below. I authorize the release of any medical or other information to patient.

My signature represents that I have read and understand the terms and statements above.

This authorization is in effect from signature date unless revoked by me in writing.

Patient's Signature Date

Parent's/Guardian's Signature Date