OBGYN-CARE
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Patient information

NAME: FIRST: …… LAST: …… MI: …..
Street: …… Apt. # ……City: …… State: … ZIP: ……..
Driver's license (photo ID) …… EXP. DATE: ……..
Phone: Home: ……..……..Cell: ……..……Work: .....
Fax#:…… E-mail: ……
Social security #: ……..... Date of birth: ……..
Employer: ……..... Job title: …… Employer address: ……..
Primary care physician: …….. Phone: ……
Preferred pharmacy contact: ……..……
Emergency contact name: ……..…….... Phone: …..……

INSURANCE INFORMATION: (PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT). IF YOU DO NOT HAVE PROOF OF INSURANCE, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED

PRIMARY INSURANCE COVERAGE:
Name of policy holder: …… Date of birth: ……..……..
Insurance company ……..…. Group #: ……..……

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)
Name of policy holder: …… Policy holder date of birth: ……..
Policy holder SSN: ……..……..…… Policy holder driver's license: ……
Policy holder employer: ……..…….. Relationship to policy holder: ..……...
INSURANCE COMPANY: ……..…. GROUP #: ……

SECONDARY INSURANCE COVERAGE:
Name of policy holder: …… Date of birth: ……..……..
Insurance company ……..…. Group #: ……..……

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)
Name of policy holder: …… Policy holder date of birth: ……..
Policy holder SSN: ……..……..…… Policy holder driver's license: ……
Policy holder employer: ……..…….. Relationship to policy holder: ..……...
INSURANCE COMPANY: ……..…. GROUP #: ……

ASSIGNMENT & RELEASE: I hereby authorize the doctor whose name appears above to furnish information to the insurance carriers concerning my illness and treatments and irrevocably assign to the doctor all payments for medical services rendered to myself or to dependents. I have read and fully understand the financial policies, including that I am responsible for any amount not covered by insurance. A photocopy of this authorization is as valid and effective as the original.

SIGNATURE: …… DATE: ……