Patient Information

The OB - GYN Place

PATIENT NAME (First Name, Middle Initial, Last Name)	PATIENT ID (Office Use Only)	FIRST PHONE (HOME)	SECOND PHONE (WORK)	THIRD PHONE (MOBILE)
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP	AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER		OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS				
PRIMARY CARE DOCTOR NAME & ADDRESS				
RACE		ETHNICITY		

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)		
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F) [ ]M [ ]F	PATIENT'S RELATIONSHIP TO RES
EMPLOYER	OCCUPATION	RES PARTY ID(Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)

[ ]Patient (same as above) [ ]Responsible Party (same as above) [ ]Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)

[ ]Patient (same as above) [ ]Responsible Party (same as above) [ ]Other (complete below)

INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP		INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS		INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

I have received the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future.

Signature of Patient or Guardian ____________________ Date ____________________

I authorize direct payment to be made to the office of The OBGYN Place for any and all medical or surgical services rendered. I understand that if any of services or charges are not covered, or if The OBGYN Place is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I also authorize the release of any medical records for the purpose of healthcare operations.

Signature of Patient or Guardian ____________________ Date ____________________