

ASSOCIATES IN OB-GYN,S.C. PATIENT REGISTRATION

PATIENT: _____
Last name, First, Middle Initial

ADDRESS: _____

CITY: _____ **ZIP CODE:** _____

WHERE MAY WE CONTACT YOU WITH TEST RESULTS, ETC ?

HOME PHONE (____) _____ **YES / NO**

WORK PHONE:(____) _____ **YES / NO**

CELL/PAGER # (____) _____ **YES / NO**

EMAIL ADDRESS: _____

BIRTHDATE: _____ **AGE:** _____

SOCIAL SECURITY #: _____

MARITAL STATUS: (CIRCLE ONE)

SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER: _____

ADDRESS: _____

REFERRED BY: _____

PRIMARY INSURANCE TYPE (CIRCLE ONE)

MEDICARE **NO INSURANCE**

PPO _____ **HMO** _____
NAME NAME

PRIVATE: _____
NAME

PRIMARY INSURANCE:
YOUR RELATIONSHIP TO CARDHOLDER (CIRCLE ONE)
SELF SPOUSE CHILD OTHER

CARDHOLDERS NAME: _____

INS. CO NAME: _____

CARDHOLDER ID: _____

EFFECTIVE DATE: _____

GROUP NAME AND OR #: _____

CARDHOLDERS EMPLOYER: _____

CARDHOLDERS BIRTHDATE: _____

CARDHOLDERS ADDRESS: _____

SECONDARY INSURANCE

CARDHOLDERS NAME: _____

INS. CO. NAME: _____

CARDHOLDERS ID #: _____

EFFECTIVE DATE: _____

YOUR RELATIONSHIP TO INSURED

GROUP NAME AND/OR # : _____

CARDHOLDERS BIRTH DATE: _____

PREFERRED PHARMACY _____

(____) _____

Pharmacy Telephone Number

Patient's or authorized person's signature. I hereby authorize the release of any medical information necessary to process claims and I authorize payment of medical and or surgical benefits to: Associates in OB-GYN,S.C:

Signature: _____

Date: _____

Associates in OB-Gyn, will file all claims to the insurance carriers. As a patient of Associates in Ob-Gyn, I understand that I am responsible for all balances unpaid by my insurance carrier. I also understand that patient balances are due in full 30 days after the insurance has made their payment. I further understand that should Associates in OB-Gyn require the services of an outside collection agency to collect a past due balance on my account, I will be responsible for all collection costs associated with my account which could exceed as much as 50% of my past due balance.

Signature: _____

Date: _____