

Date _____ Dr.# _____ Chart# _____

SOCIAL SECURITY # _____ DOB _____ AGE _____ MARITAL STATUS S M D W
(circle one)

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ E MAIL ADDRESS _____

EMPLOYER _____ WORK# _____

HUSBAND'S NAME _____ HIS SS# _____

HUSBAND'S EMPLOYER _____ HIS WK.# _____

RESPONSIBLE PARTY _____ PHONE # _____

ADDRESS _____

Street City State Zip

Emergency Contact _____

(not same household) (Name) (Phone)

Primary Care Physician/Referring Physician _____

(circle one)

How did you find out about our practice?

Phy. Referral _____ Mobile Ob-Gyn Emp. _____

Mobile Ob-Gyn Patient _____ Other _____

INSURANCE INFORMATION (WE MUST HAVE COPY OF INSURANCE CARD)

Primary Insurance _____ Policy # _____

Group # _____ Policy Holder _____

Employer _____

Secondary Insurance _____ Policy # _____

Group # _____ Policy Holder _____

Employer _____

I give my permission to Mobile Ob-Gyn, P.C. to administer treatment and perform necessary minor operative procedures in diagnosing and/or treating my condition. By signing this form I am granting consent to Mobile Ob-Gyn, P.C. to use and disclose protected health information for the purposes of treatment, payment and health care operations. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. (You have the right to request us to restrict how we use and disclose your protected health information. We are not required by law to grant your request, but if we do, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.)

I agree to be personally and fully responsible for payment. In case of default I will be responsible for all costs incurred in the collection of this and future outstanding balances.

SIGNATURE _____ DATE _____