Comprehensive OB/GYN Demographics

Patient Information Please Print

O Dr. O Miss O Ms. O Mrs. Date of Birth _____

Last Name _____ First Name _____ MI _____ SSN _____

Address _____ City, State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

O White O Black O Asian O Native American O Pacific Islander O Other O Declined O Hispanic O Not Hispanic O Declined

O English O Spanish O Other _____ O Single O Married O Divorced O Widowed O Separated O Partner

Employment: O Full-Time O Part-Time O Not Employed O Self Employed O Retired O Active Military Student: O Full-Time O Part-Time

Employer Name _____ Work Phone _____

Emergency Contact Name _____Relationship _____

Cell Phone _____ Home Phone _____ Alt Phone Number _____

Primary Care Physician _____ Phone Number _____

Pharmacy _____Phone Number _____

How did you find out about us?_____

Responsible Party Applies to Minors Only

O Parent O Other _____ Date of Birth _____SSN _____

Name _____ Phone Number _____

Address _____

Primary Insurance Please provide copy of insurance card

Insurance Company _____ Name of Insured _____

Relationship to Insured _____ Date of Birth _____ SSN _____

Address (if different from patient) _____

Policy Number _____ Group Number _____ Effective Date _____

Secondary Insurance Please provide copy of insurance card

Insurance Company _____ Name of Insured _____

Relationship to Insured _____ Date of Birth _____ SSN _____

Address (if different from patient) _____

Policy Number _____ Group Number _____ Effective Date _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to ***Comprehensive OB/GYN*** and any assisting physicians for the services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payments of benefits. I further agree a photocopy of this agreement shall be as valid as the original.

Date _____ Patient Signature/Responsible Party _____