Southwest Obstetrics and Gynecology

Who Referred You?_____

PATIENT INFORMATION SHEET

Name: _____ **Birth Date:** _____

Address: _____ **Telephone:** _____

Mobile/Cell: _____ **e-mail:** _____

City: _____ **State:** _____ **Zip:** _____

Marital Status: Single Married Divorced Widowed **Social Security #:** _____

Employer:_____ **Occupation:** _____

Racial Demographics: Caucasian/White Native American (Tribe: _____)

(Circle One or More) Black/African America Asian DECLINED

Ethnic Group (Circle One): Hispanic Non-Hispanic

Preferred Contact Method (circle): Home Phone Cell Phone e-Mail

Preferred Reminder Method (Circle): Mail Home Phone Cell Phone/Text Msg e-Mail

PRIMARY INSURANCE INFORMATION

Carrier Name: _____ **Telephone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ID #: _____ **Group #:** _____

SUBSCRIBER INFORMATION (Parent or Spouse Data-Required for Insurance Billing)

Subscriber Name: _____ **SS#:** _____ **Birth Date:** _____

Relationship to Insured (Circle One): Self Spouse Child Other:_____

Employer: _____ **Occupation:** _____

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip:** _____

SECONDARY INSURANCE

Carrier Name: _____ **Telephone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

ID #: _____ **Group #:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Address: _____ **Telephone:** _____

City: _____ **State:** _____ **Zip:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I assign all medical/surgical benefits to which I am entitled, including private insurance to Southwest Obstetrics and Gynecology, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information related to the diagnosis and treatment, including records protected by Federal Regulations as required to qualify for health benefit payment. I will receive a separate bill for anything sent to an outside lab. I understand that I am financially responsible for all charges incurred from medically treatment at this facility, whether they are paid by my insurance carrier or not. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees, and collection costs.

Signature: _____ **Date:** _____

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www.Southwest-OBGYN.net