EMERALD OBSTETRICS AND GYNECOLOGY, LLC

PATIENT INFORMATION – PLEASE PRINT

DATE: ___________________

NAME: ____
LAST FIRST MI MAIDEN

ADDRESS: ____
STREET CITY STATE ZIP CODE

( ) ( ) ( )
HOME PHONE WORK PHONE CELL PHONE

- - / / ( )
SSN DOB (AGE) RACE ETHNICITY

S M D W
PREFERRED LANGUAGE MARITAL STATUS (CIRCLE ONE) EMAIL ADDRESS

PATIENT'S EMPLOYER: ______________________ OCCUPATION: ______________________ FT / PT

EMPLOYER'S ADDRESS: ____
STREET CITY STATE ZIP CODE

PRIMARY CARE PHYSICIAN: ______________________ REFERRING PHYSICIAN: ______________________

PERSON FINANCIALLY RESPONSIBLE: ____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY

POLICY HOLDER'S NAME

POLIDY HOLDER'S DOB POLICY HOLDER'S SSN

POLICY # GROUP #

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY

POLICY HOLDER'S NAME

POLICY HOLDER'S DOB POLICY HOLDER'S SSN

POLICY # GROUP #

SPOUSE'S NAME: ______________________________________ - - / / ( )
LAST FIRST MI SSN DOB (AGE)

SPOUSE'S EMPLOYER: ______________________________________ ( )
OCCUPATION WORK PHONE FT / PT

EMERGENCY CONTACT: ____
LAST FIRST RELATIONSHIP TO PATIENT

( ) ( ) ( )
HOME PHONE CELL PHONE WORK PHONE EMPLOYER

I have read and understand the above information and I agree to be personally and fully responsible as indicated if my insurance carrier or payer denies payment. I authorize Emerald Obstetrics and Gynecology, LLC to release to my insurance company(s) any information relative to my treatment. I authorize Emerald Obstetrics and Gynecology, LLC and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

SIGNATURE: ______________________________ (OR PARENT IF A MINOR) DATE: ______________