

Northeast OB/GYN, S.C.

Appointment with Dr. _____

Referred by: _____

_____	_____	_____	<u>S</u> <u>M</u> <u>D</u> <u>W</u>
Last Name	First Name	M.I.	Marital Status

Address _____

City _____ State _____ Zip _____

Home Phone Number _____ - _____ - _____

Cell Phone Number _____ - _____ - _____

Work Phone Number _____ - _____ - _____

Birth date _____

Social Security Number _____ - _____ - _____

If you would like to receive results and reminders by email, please provide your email address.

Email _____

Emergency Contact

Name _____ Relationship _____

Phone Number _____ - _____ - _____ Address _____

Work Information

Employer _____ Occupation _____

Phone Number _____ - _____ - _____ Address _____

Spouse/Guardian

Name _____ Phone Number _____ - _____ - _____

Employer _____ Occupation _____

Social Security Number _____ - _____ - _____ Birth Date _____

Primary Insurance Name _____

ID Number _____ Group Number _____ Effective Date _____

Policy Holder's Name _____ Relationship _____

Secondary Insurance Name _____

ID Number _____ Group Number _____ Effective Date _____

Policy Holder's Name _____ Relationship _____

My insurance company requires my lab tests go to: _____

The hospital that I would go to for treatment would be: _____

The pharmacy that I use for prescriptions: _____

Address _____ Phone Number _____ - _____ - _____

All professional services rendered are charged to the patient.

Necessary forms will be completed to help expedite insurance carrier payments.

However, the patient is responsible for all fees including late charges and obtaining referrals, regardless of insurance coverage.

It is also customary to pay for services when rendered unless other arrangements have been made in advance with the business office.

Acknowledgment

I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to NORTHEAST OB/GYN for any services furnished me by that party who accepts assignment/clinician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical information about me to release to the Social Security Administration Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare/other insurance company claim.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment.

(Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature

_____/_____/_____
Date