Lake Obstetrics and Gynecology, Inc.

PATIENT INFORMATION

Pharmacy: _____

Rx Consent: Y N _____ Race: _____

Ethinicity: _____

Language: _____

E-mail: _____

Primary Care Doctor: _____

Social Security #: _____

Legal Name: _____
LAST FIRST MI NICKNAME

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Occupation: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____City: _____ State: _____ Zip: _____

Work: ❑ FT ❑ PT Student: ❑ FT ❑ PT

Date of Birth: _____ Marital Status: M ___ S ___ D ___ W ___

Who referred you to our Practice? _____

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:		
Policy Holder Name:		
Relationship to Patient:		
Address:		
City, State, Zip:		
Social Security Number:		
Date of Birth:		
Employer:		

***** PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR PHOTOCOPYING *****

Maiden Name: _____

Spouse's Name: _____
LAST FIRST MI

Spouse's Employer: _____ **Work Phone:** _____

Whom should we contact in case of an emergency? _____ **Phone #:** _____

Relationship to Patient? _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY BILL.

I irrevocably assign the benefits payable for covered services to the physician or organization furnishing the services. I authorize any holder of medical information about me to release any information needed to process this claim. I, the patient assume responsibility for any co-pays, deductibles, non-covered, or unpaid services. Additionally, I understand that if I am in default in paying my bill and a collection agency is engaged, I will be responsible for any fees resulting from this action.

_____
PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**

OR

For patients with MEDICARE, please read and complete the following:

I certify that the information given by me applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____
PATIENT'S SIGNATURE **DATE**