EASTERN OB|GYN

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Patient Information

Patient Name: First Middle or Maiden Last	Home #: ( )	Cell #: ( )	Email Address:
Address:	City:	State:	Zip:	Social Security No.:
Referred By: · Physician · Relative · Friend Name:	Primary Care Physician:	Date of Birth:	Gender:
· Married · Divorced · Single · Widowed · Separated	Driver's License No:	Ethnicity: · Hispanic or Latino · Not Hispanic or Latino	Race:
Spouse's Name:	Spouse's Date of Birth:	Spouse's Social Security No:	
Children's Name(s) & Date of Birth:			
Preferred Pharmacy (Name and Location):	Preferred Method of Communication: Email Mail Cell # Home # Work # Text		

Employment Information

Employer:	Work Phone: ( )	Occupation:

Primary Insurance Information

Primary Insurance:	Contract #:	Group #:	
Policyholder:	Date of Birth:	Relationship To Patient:	
Address:	City:	State:	Zip:
Social Security No.:	Home Phone: ( )	Employer:	Work Phone: ( )
Secondary Insurance:	Contract #:	Group #:	
Policyholder:	Date of Birth:	Relationship To Patient:	
Address:	City:	State:	Zip:
Social Security No.:	Home Phone: ( )	Employer:	Work Phone: ( )

Emergency Information

Person To Contact In Case of Emergency Other Than Spouse:	Relationship To Patient:	Person's Phone #: ( )

Authorization To Release Information And Assignment Of Benefits

I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for the medical or physician charges not covered by this authorization.
I hereby authorize the release of medical records to my insurance company, if requested to process a claim for my charges.
This information is given for the purpose of establishing or updating records with Eastern OB/GYN, P.C.
It is my understanding that any and all records here concerning my personal and medical history are the confidential property of Eastern OB/GYN, P.C.
I understand that I am responsible for any and all charges incurred by me or us, and that I agree to pay any collection costs incurred, including reasonable attorney's fees. **Payment is due at the time of medical services rendered, except for HMO plans (UHC, PMD…for these the office copay is required at the time of medical services rendered.)** I hereby waive to the extent allowed by law, all personal property rights of exemption under the constitution and laws of the State of Alabama, in connection with or related to the collection of any amounts due for services rendered.
Itemized charge tickets are provided each visit for reimbursement by your insurance carrier.
Patients covered by any type of insurance plan should remember that they are responsible for all charges incurred, regardless of their plan coverage.

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Signature Signature of Guardian (if applicable) Date