Glendale Obstetrics & Gynecology, PC

Patient Information

Name: _____ Birthdate: _____

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Address: _____ City, State, Zip: _____

Primary Phone: _____ Secondary Phone: _____

E-Mail Address: _____ Referred by: _____

Employer: _____ Occupation: _____

Race: ☐Am. Indian or Alaskan Native ☐ Black or African Am. ☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐Declined

Ethnicity: ☐ African ☐ Arab ☐ Ashkenazi Jew ☐ Chinese ☐ German ☐ Hispanic or Latino ☐ Indian ☐ Iranian ☐ Japanese ☐ Mediterranean

☐ Scandinavian ☐ Slavic ☐ Slovak ☐ Unknown ☐ Declined

Primary Care Physician and Number: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Spouse (if married) or Parent (if minor)

Name: _____ Birthdate: _____

Social Security #: _____ Employer: _____

Address: _____ City, State, Zip: _____

Phone: _____ Relationship: _____

Insurance Information

Primary Insurance: _____

ID#: _____ Group#: _____

Policy Holder: _____

Policy Holder Birthdate: _____

Relationship to Patient: _____

Secondary Insurance: _____

ID#: _____ Group#: _____

Policy Holder: _____

Policy Holder Birthdate: _____

Relationship to Patient: _____

Assignment, Authorization & Consent to Treat

I acknowledge that all the above information is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives her confidentiality rights should collection action become necessary. I hereby authorize and request that payment under my insurance plans be made directly to Glendale OBGYN for any services furnished to me. I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which, in the judgement of Glendale OBGYN may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedures, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims including any information referring to alcohol, drug abuse, and/or AIDS. I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians and other involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at any time.

Signature: _____ Date: _____