

Genesis Ob/Gyn, Inc.

PATIENT INFORMATION SHEET

(Please Print)

DATE _____ DOCTOR _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE _____
LAST NAME _____ FIRST NAME _____ M.I. _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME PHONE _____ PAGER/MOBILE _____
OCCUPATION _____
EMPLOYER _____ BUSINESS PHONE _____
MARITAL STATUS: SINGLE MARRIED DIVORCED OTHER
STUDENT: FULL-TIME PART-TIME
REFERRED BY: _____

SPOUSE / PARENT INFORMATION

FULL NAME _____ RELATIONSHIP _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ PHONE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
OCCUPATION _____
EMPLOYER _____ BUSINESS PHONE _____

IN CASE OF EMERGENCY, PLEASE NOTIFY (OTHER THAN SPOUSE) RELATIONSHIP _____
NAME _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
ADDRESS _____	ADDRESS _____
EMPLOYEE'S NAME _____	EMPLOYEE'S NAME _____
EMPLOYEE'S S.S.# _____	EMPLOYEE'S S.S.# _____
EMPLOYEE'S DATE OF BIRTH _____	EMPLOYEE'S DATE OF BIRTH _____
EMPLOYER _____	EMPLOYER _____
GROUP# _____ ID# _____	GROUP# _____ ID# _____
EFFECTIVE DATE _____ CO-PAY AMT. _____	EFFECTIVE DATE _____ CO-PAY AMT. _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS.

ASSIGNMENT AND RELEASE STATEMENT:

I HEREBY AUTHORIZE THAT MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICIAN, AND I AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES; AND I AGREE TO PAY FOR ANY AND ALL MEDICAL SERVICES I RECEIVE FROM THE DOCTORS/PROVIDERS OF THIS PRACTICE THAT MY INSURANCE COMPANY REFUSES TO PAY, FOR WHATEVER REASON. THIS OFFICE WILL FILE A CLAIM IN MY BEHALF. HOWEVER, IF MY INSURANCE COMPANY DENIES PAYMENT FOR ANY REASON (e.g. NON-COVERED SERVICES, DOES NOT PAY FOR PREVENTIVE MEDICINE VISITS, MY FAILURE TO SECURE A REFERRAL FROM MY PRIMARY CARE PHYSICIAN), I WILL PAY FOR SAME UPON WRITTEN/VERBAL NOTICE OF THEIR REFUSAL; AND IN THE EVENT I DO NOT PAY FOR THESE OR ANY OTHER SERVICES PROVIDED ME WHEN DUE, I AGREE TO PAY ALL COST OF COLLECTION.

SIGNATURE _____ DATE _____

CONSENT TO TREATMENT:

I HEREBY AUTHORIZE MEMBERS OF GENESIS OB/GYN, INC. HEALTHCARE TEAM TO PROVIDE TREATMENT AS NECESSARY.

SIGNATURE _____ DATE _____