

**NAME (PLEASE PRINT)**

DATE \_\_\_\_\_

FIRST					M.I.	LAST					NAME YOU GO BY																		
MARITAL STATUS					DATE OF BIRTH					AGE					SOCIAL SEC. NO.					DL #									
S	M	W	D	SEP																									
STREET ADDRESS										CITY AND STATE										ZIP CODE					HOME PHONE NO.				
PATIENT'S EMPLOYER										OCCUPATION (INDICATE IF STUDENT)										HOW LONG EMPLOYED					WORK PHONE NO.				
EMPLOYER'S STREET ADDRESS										CITY AND STATE										ZIP CODE									

In case of an emergency whom may we contact? \_\_\_\_\_

Nearest friend not living with you										Phone No.				
Landlord										Phone No.				
Physician					Name					Phone No.				
Dentist					Name					Phone No.				

**SPOUSE/PARENT INFORMATION**

Is it okay to leave a message on answering machine verifying appt. etc? Yes or No

HUSBAND'S NAME										PARENT'S NAME, IF MINOR																			
HUSBAND'S OR PARENT'S EMPLOYER										OCCUPATION										HOW LONG EMPLOYED					WORK PHONE NO.				
ADDRESS OF HUSBAND OR PARENT'S EMPLOYER										CITY AND STATE										ZIP CODE									
NEAREST RELATIVE NOT LIVING WITH YOU										ADDRESS										PHONE NO.									

**INSURANCE INFORMATION**

NAME OF INSURANCE CO.										INSURED PERSON										RELATIONSHIP TO PATIENT				
CONTRACT NUMBER OF INSURED										GROUP #										DATE OF BIRTH OF INSURED				
SECONDARY INSURANCE										INSURED PERSON										RELATIONSHIP TO PATIENT				
CONTRACT NUMBER OF INSURED										GROUP #										DATE OF BIRTH OF INSURED				

MEDICARE NUMBER										MEDICAID NUMBER									
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How did you hear about us? yellow pages, relative, friend, other \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

I will be paying by \_\_\_\_\_ cash \_\_\_\_\_ check \_\_\_\_\_ credit card Name of bank you use: \_\_\_\_\_

**CONSENT FOR TREATMENT - RELEASE OF MEDICAL INFORMATION - FINANCIAL RESPONSIBILITY**

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize release of any or all medical records to referring physicians, my insurance carriers, or those involved in payment of my account. I further acknowledge full financial responsibility for any services rendered by OB/GYN Associates, P.A. and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to OB/GYN Associates, P.A. In the event an account is not paid within 90 days, the undersigned agrees to pay all costs of collection including attorneys fees and hereby waives all right of exemption under the constitution of the State of Alabama.

DATE _____	_____
	PATIENT SIGNATURE
DATE _____	_____
	PATIENT/GUARDIAN SIGNATURE IF PATIENT IS UNDER AGE 14