

Pt Number: _____

Date: _____

Medical Rec Loc: _____

PATIENT INFORMATION

NAME: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip _____

Home Phone: (____) _____

Cell Phone: _____

SSN: _____

Race: _____

Marital Status: S M W D Sep

Email Address: _____

How did you hear about our clinic?

Referring Physician: _____

EMPLOYER ADDRESS or SCHOOL:

Name: _____

Address: _____

Work Phone: (____) _____

Occupation: _____

EMERGENCY CONTACT:

Name: _____

Home Phone: _____

Work Phone: _____

Relationship: _____

Primary Care Physician: _____

INSURANCE INFORMATION:

Primary Insurance:

Insurance Name: _____

Policy Holder Name: _____

Date of Birth: _____

SSN: _____

Group Name: _____

Group #: _____

Policy ID#: _____

Policy Holder Employer: _____

Address: _____

Phone: _____

Relationship to Subscriber: _____

Secondary Insurance:

Insurance Name: _____

Policy Holder Name: _____

Date of Birth: _____

SSN: _____

Group Name _____

Group #: _____

Policy ID#: _____

Policy Holder Employer: _____

Address: _____

Phone: _____

Relationship to Subscriber: _____

ASSIGNMENT OF BENEFITS

I hereby authorize that payment due me in my pending insurance claim be made directly to Oakdale Obstetrics & Gynecology, P.A. Payment is authorized upon receipt of an itemized statement.

Signed _____ Date _____

RECORDS RELEASE

I hereby authorize Oakdale Obstetrics & Gynecology, P.A. to release to my referring physician or insurance company information including diagnosis and records or treatment concerning past medical history and current care. (Should you refuse to sign the records release, your insurance plan may not pay your claim and you will be billed).

Signed _____ Date _____

SENSITIVE INFORMATION RELEASE

I hereby authorize Oakdale Obstetrics & Gynecology, P.A. to release my referring physician or insurance company information including diagnosis and records or treatment concerning past medical history and current care regarding (please circle any items below you **do not** want released):

Mental Health/Psychiatric Disorders * Chemical Dependency * HIV/Aids Virus * STDs * Pregnancy * Research Study Info.

Signed _____ Date _____ Revised 01/13/06