Premier ObGyn, LLC
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PATIENT INFORMATION FORM

PATIENT'S FULL NAME: _____
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS: _____
STREET CITY STATE ZIP CODE

SS#: _____ **DATE OF BIRTH:** _____ **AGE:** _____

HOME #: _____ **CELL #:** _____ **WORK #:** _____

VOICEMAIL / MESSAGE MAY BE LEFT AT – Circle all that apply HOME CELL WORK

MARITAL STATUS: MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ SEPARATED _____

PATIENT'S EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYMENT ADDRESS: _____

LEGAL GUARDIAN: **FULL NAME:** _____ **RELATIONSHIP TO PATIENT:** _____
EMPLOYER: _____ **WORK #:** _____
EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

PRIMARY CARE DOCTOR: _____ **ADDRESS:** _____

HOW DID YOU HEAR ABOUT US? DOCTOR FAMILY/FRIEND ADVERTISING INSURANCE

********** INSURANCE INFORMATION **********

PRIMARY INSURANCE CO. _____
CLAIMS MAILING ADDRESS _____
ID# _____ **GROUP#** _____
POLICY HOLDER NAME _____
RELATIONSHIP _____ **D.O.B.** _____
SOCIAL SECURITY # _____

SECONDARY INSURANCE CO. _____
CLAIMS MAILING ADDRESS _____
ID# _____ **GROUP#** _____
POLICY HOLDER NAME _____
RELATIONSHIP _____ **D.O.B.** _____
SOCIAL SECURITY # _____

********** PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE **********

I CERTIFY THAT THE INFORMATION I HAVE REPORTED HEREIN IS CORRECT. I AUTHORIZE THE RELEASE OF ANY INFORMATON NECESSARY IN ORDER TO PROCESS INSURANCE CLAIMS AND DO ASSIGN TO PREMIER OBGYN, LLC ALL MONIES TO WHICH THEY ARE ENTITLED FOR MEDICAL AND/OR SURGICAL EXPENSES RELATED TO THIS CARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE COMPANY AND THAT OUTSTANDING BALANCES NOT PAID BY MY INSURANCE CARRIER AFTER 90 DAYS WILL BE DUE AND PAYABLE IN FULL BY ME AT THAT TIME. IN ADDITION, I AM RESPONSIBLE FOR ANY CHARGES INCURRED TO COLLECT ON OVERDUE ACCOUNTS AND INTEREST MAY BE CHARGED ON OUTSTANDING BALANCES. THE DIAGNOSTIC LABORATORY OF RECORD IS BIO-REFERENCE. I UNDERSTAND THAT IF I DO NOT INFORM PREMIER OBGYN, LLC THAT MY DIAGNOSTIC LABORATORY WORK MUST BE SENT TO ANY OTHER LABORATORY, I WILL BE FINANCIALLY RESPONSIBLE IN THE ENTIRETY FOR ALL LAB SERVICES PERFORMED ON MY BEHALF IF NOT COVERED BY MY INSURANCE PLAN. I PERMIT INFORMATION ABOUT MY HEALTH CARE BE LEFT ON MY HOME ANSWERING MACHINE. I MAY WITHDRAW MY PERMISSION AT ANY TIME WITH WRITTEN NOTICE.

_____ _____
Patient Signature Today's Date (MM/DD/YYYY)

*****PAYMENT FOR CONSULTATION OR OFFICE VISIT IS EXPECTED AT TIME OF SERVICE*****