

Patient Information

**FOR OFFICE
USE ONLY**

Chart No.

Date

PLEASE FILL OUT COMPLETELY (Please Print)

Last Name		First	Middle	Maiden	Age
Mailing Address		Street Address		City	State Zip Code
Date of Birth	S.S. No.	Home Phone		Mother's Maiden Name	
Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated		Person to notify in case of Emergency other than Husband or Nearest Relative			Phone No.

PATIENT'S EMPLOYMENT / SCHOOL INFORMATION

Employer/School Name/Job Title	Address	City/State	Zip Code	Phone No.	Ext. / Dept.
Husband or Nearest Relative	Phone No.	Relationship to Patient	Husband or Nearest Relative's Employer City & state (only)	Phone No.	
Husband or Nearest Relative's Home Address (include city, state & zip) <input type="checkbox"/> same <input type="checkbox"/> other		Husband's S.S. No.	Husband's Date of Birth		

INSURANCE INFORMATION (Complete if insurance is in your name)

Name of Insurance Company		Policy/SS No.
Group No.	Medicare No.	Medicaid No.

COMPLETE IF INSURANCE IS NOT IN YOUR NAME

Policy Holder's Name		Relationship to Patient
Policy Holder's Date of Birth	Name of Insurance Company	
Policy/SS No.	Group No.	Employer Name

REFERRED BY

Referred by Doctor (name)	Address (city and state)	Other (please check) <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____
Primary Care Physician (name)	Address (city and state)	

INSURANCE AUTHORIZATION, ASSIGNMENT AND FINANCIAL RESPONSIBILITY:

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL MEDICAL EXPENSES. PAYMENT IS EXPECTED AT THE TIME OF SERVICE OR SERVICES UNLESS PRIOR APPROVAL HAS BEEN ARRANGED OR I AM A MEMBER OF A MANAGED CARE, HMO OR PPO OF WHICH COURTVIEW OB/GYN, P.A. PARTICIPATES. I AM RESPONSIBLE FOR ANY INSURANCE CO-PAYMENT AT THE TIME OF SERVICE AND I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY SERVICE NOT COVERED BY MY INSURANCE PLAN.

I PLAN TO PAY BY: CASH CHECK VISA/MASTERCARD RETURNED CHECK FEE: \$20.00

AUTHORIZATION TO PAY BENEFITS TO COURTVIEW OB/GYN, P.A.:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO COURTVIEW OB/GYN, P.A. OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THESE SERVICES.

SIGNED (PATIENT, PARENT OR GUARDIAN) _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE COURTVIEW OB/GYN, P.A. TO RELEASE ANY INFORMATION REQUIRED TO INSURANCE CARRIERS AND/OR PRIMARY CARE PHYSICIANS IN THE COURSE OF MY EXAMINATIONS OR TREATMENTS INCLUDING INFORMATION RELATED TO PSYCHIATRIC CARE, DRUG AND ALCOHOL ABUSE AND HIV/AIDS CONFIDENTIAL INFORMATION, NECESSARY TO PROCESS INSURANCE CLAIMS OR ANY MEDICAL INFORMATION THAT IS NEEDED FOR ANY UTILIZATION REVIEW OR QUALITY ASSURANCE ACTIVITIES. I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED TO COURTVIEW OB/GYN, P.A.. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Patient _____ Date _____

Relationship if not patient (or person giving consent) _____ Patient unable to sign due to _____

PLEASE GIVE FORM TO THE RECEPTIONIST WHEN YOU HAVE COMPLETED IT ALONG WITH YOUR INSURANCE CARD/CARDS AND DRIVERS LICENSE. THANK YOU!