ASSOCIATED GYNECOLOGY: PATIENT DEMOGRAPHICS

REFERRING PHYSICIAN:_____

Name:_____DOB:_____SS#:_____

Marital Status:_____ Home Phone:_____ Work#_____Cell #_____

Address:_____City_____ State_____Zip_____

Employer_____ Work Address_____

Spouse/Parent_____ DOB:_____SS#_____ Relation_____

Spouse Employer_____Work Address:_____

INSURANCE CO_____ Copy of Card Attached _____ Copay $_____(specialist)

Subscriber Name_____Relation to patient_____Subscriber DOB:_____

Secondary Insurance:_____ Subscriber_____Relationship_____

Emergency contact:
_____Phone_____Relationship_____

Lab required by insurance _____ Radiology required by insurance_____

CONTACT INFO: What is best way to get hold of you from 8-5: Work Cell Home OK to leave msg_____

RELEASE OF HEALTH INFORMATION:
We can only give information about you to you. If you would like to give us permission to discuss protected information with other family members, please fill out name and circle yes or no for each and initial.

Spouse/other _____Medical Issues Yes NO Insur/billing Yes NO _____(initial)

HIPPA:
Please initial that you have received or been offered a copy of our HIPPA policy for protected health information _____(initial)

Do you have an ADVANCED DIRECTIVE: ____yes ___no
TYPE: ___Living Will or ____Durable Power of Attorney for Health Care
Please provide copy of your Advance Directive to our office for your file.

Would you like information on Advance Directives? ____yes _____no

I, the undersigned, certify that I or my dependent have insurance coverage with the above named insurance company, and assign directly to ASSOCIATED GYNECOLOGY, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submission forms.

_____ _____ _____
Signature of responsible party Relationship to patient Date