EMERALD OBSTETRICS AND GYNECOLOGY, LLC

PATIENT INFORMATION – PLEASE PRINT

DATE: ________________

NAME: ____
LAST FIRST MI MAIDEN

ADDRESS: ____
STREET CITY STATE ZIP CODE

( ) ______________ ( ) ______________ ( ) ______________
HOME PHONE WORK PHONE CELL PHONE

- - ______ / / ( ) ______________________________
SSN DOB (AGE) RACE ETHNICITY

______________ S M D W ______________________________
PREFERRED LANGUAGE MARITAL STATUS (CIRCLE ONE) EMAIL ADDRESS

PATIENT'S EMPLOYER: ______________________ OCCUPATION: ______________ FT / PT

EMPLOYER'S ADDRESS: ____
STREET CITY STATE ZIP CODE

PRIMARY CARE PHYSICIAN: ______________________ REFERRING PHYSICIAN: ______________________

PERSON FINANCIALLY RESPONSIBLE: ____

PRIMARY INSURANCE		SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
POLICY HOLDER'S NAME		POLICY HOLDER'S NAME	
POLIDY HOLDER'S DOB	POLICY HOLDER'S SSN	POLICY HOLDER'S DOB	POLICY HOLDER'S SSN
POLICY #	GROUP #	POLICY #	GROUP #

SPOUSE'S NAME: ______________________________________ - - / / ( )
LAST FIRST MI SSN DOB (AGE)

SPOUSE'S EMPLOYER: ______________________________ ( ) ______________
OCCUPATION WORK PHONE FT / PT

EMERGENCY CONTACT: ____
LAST FIRST RELATIONSHIP TO PATIENT

( ) ______________ ( ) ______________ ( ) ______________ ______________
HOME PHONE CELL PHONE WORK PHONE EMPLOYER

I have read and understand the above information and I agree to be personally and fully responsible as indicated if my insurance carrier or payer denies payment. I authorize Emerald Obstetrics and Gynecology, LLC to release to my insurance company(s) any information relative to my treatment. I authorize Emerald Obstetrics and Gynecology, LLC and/or any entity authorized by my healthcare provider, to contact me by using any telephone number, email address, and/or mailing address provided, unless otherwise indicated.

SIGNATURE: ______________________________ (OR PARENT IF A MINOR) DATE: ______________