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	Cell Phone	Mother's Maiden Name

Marital Status: ☐ Divorced ☐ Widowed ☐ Single ☐ Married ☐ Separated	Person to notify in case of Emergency other than Husband or Nearest Relative	Phone No.

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)* ☐ same ☐ other	Husband's S.S. No.	Husband's Date of Birth

PATIENT'S EMPLOYMENT / SCHOOL INFORMATION

Employer/School Name/Job Title	Address	City/State	Zip Code	Phone No.	Ext. / Dept.

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) ☐ Yellow Pages ☐ Friend
Primary Care Physician *(name)*	Address *(city and state)*	☐ Newspaper ☐ Other_____

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_____ Patient unable to sign due to _____
(or person giving consent)

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