



Obstetrics and Gynecology
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PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL		
SOCIAL SECURITY #	DATE OF BIRTH	AGE	SEX	
STREET ADDRESS/P.O. BOX	APT. #	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	MARITAL STATUS	REFERRED BY	
EMPLOYER	EMPLOYER'S ADDRESS	OCCUPATION	BUSINESS PHONE	

SPOUSE INFORMATION (if applicable) OR RESPONSIBLE BILLING PARTY INFORMATION

NAME	SOCIAL SECURITY #	DATE OF BIRTH
CELL PHONE	EMPLOYER	EMPLOYER'S ADDRESS
NEAREST FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT	PHONE

RESPONSIBLE PARTY/MEDICAL INFORMATION

I authorize the release of any medical information and/or payment of medical payments of medical benefits to the undersigned physician or supplier for service. I understand that if I receive any payment from my insurance company, I am obligated to sign it over to the physician. Failure to do so could be construed as fraud and not dischargeable in bankruptcy action. I accept responsibility for my account balance.

Patient Signature _____ Date _____

Signature of insured or responsible party _____
(if other than patient)