NORTHWEST OHIO OBSTETRICS & GYNECOLOGY

DATE:_____ **Social Security Number:**_____

PATIENT INFORMATION (Please Print Clearly) **EMAIL ADDRESS:**_____

Patient's Full Name:_____ Age: _____ DOB: _____ Race: _____

Ethnic Background: (Check one) Caucasian _____ Black _____ Hispanic _____ Other _____

Address:_____ City:_____ ZIP:_____ Preferred Language: _____

Home Phone:_____ Cell Phone:_____ Pharmacy: _____

Married_____ Single_____ Divorced_____ Separated _____ Widowed_____

Patient's Employer:_____ Phone:_____

Address:_____ City:_____ ZIP:_____

Occupation:_____

Spouse's Name: _____ DOB: _____ SS#:_____

Spouse's Employer and Address:_____

Best Time to Contact You:_____ At Which Phone #:_____

Family Physician: _____ Referred By:_____

INSURANCE INFORMATION

If you are not covered on your own policy, are you covered by a SPOUSE or PARENT (Please Circle One)

Policy Holder's Name:_____ Social Security Number:_____

Employer:_____ Work Phone:_____

Employer Address:_____City:_____ZIP:_____

Occupation:_____DOB:_____

If you have insurance, please present your card at the time of your visit, otherwise you will be responsible for billing your own insurance. If your particular insurance carrier requires a referral form or specific claim form, etc., it is your responsibility to provide us with it. **Please keep us informed of any changes regarding the above information.**

EMERGENCY CONTACT

Name:_____

Relationship:_____ Phone:_____

Address:_____ City:_____ ZIP:_____

PLEASE TURN OVER AND SIGN

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claims. I certify that information I have reported with regard to my insurance coverage is correct.

I hereby authorize **NORTHWEST OBSTETRICS & GYNECOLOGY** to apply for benefits on my behalf for covered services rendered by its doctors, nurses or by their orders. I request that payment from my insurance company be made directly to **NORTHWEST OBSTETRICS & GYNECOLOGY**.

I authorize a copy of this authorization to be used in place of original. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ X_____
Date Signature (Patient, parent or guardian)

I authorize the release of medical information, as necessary for my medical care, to my referring physician or to other medical personnel directly involved in my treatment. The transmittal of the records may be direct, by mail, my facsimile or by telephone.

I also authorize release of medical information to the following people: (Examples: parents, spouse, children, guardian. Please write their full name.)

_____

_____

This authorization may be revoked by me at any time in writing.

_____ X_____
Date Signature (Patient, parent or guardian)

CONSENT FOR TREATMENT / FINANCIAL AGREEMENT

I consent to treatment necessary or desirable to the care of the patient mentioned above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, his nurse or qualified designate. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service. I understand that the charges made for professional services may not be covered in full by insurance. Although insurance may be filed, I understand that the patient or the responsible party is solely responsible for the payment of all services. I understand that if I am unable to keep a scheduled appointment, I must give at least twenty-four hours notice or I will be charged $25 (this is not covered by any insurance and you will be responsible for payment). If my account becomes delinquent in payment, I agree to pay all costs of collection, including reasonable attorney's fees.

_____ X_____
Date Signature (Patient, parent or guardian)

Do you have a Living Will? YES NO If no, please ask us about information regarding a Living Will.