

WARREN OBSTETRICS AND GYNECOLOGY

PATIENT INFORMATION

Email address where we can contact you: _____@_____

NAME _____ DATE OF BIRTH ____/____/____

PLEASE CHECK: MALE FEMALE CHILD MARRIED SINGLE DIVORCED WIDOWED

ADDRESS _____
NUMBER STREET APT# CITY STATE ZIP

HOME PHONE (____) _____ - _____ WORK (____) _____ - _____ CELL/PAGER (____) _____ - _____

SOCIAL SECURITY _____ - _____ - _____ DRIVER'S LICENSE # _____

YOUR EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____
NUMBER STREET CITY STATE ZIP

Under whom is the insurance policy? ME MY SPOUSE OTHER: _____
Who referred you to this clinic? _____

SPOUSE'S INFORMATION

SPOUSE'S NAME _____ DATE OF BIRTH ____/____/____

SSN# _____/_____/_____ EMPLOYER'S NAME _____

ADDRESS _____ OCCUPATION _____

HOME PHONE (____) _____ WORK PHONE (____) _____ CELL/PAGER (____) _____

IF PATIENT IS A CHILD AND IS INSURED UNDER PARENT OR GUARDIAN - PLEASE FILL OUT

INSURED'S NAME _____ DATE OF BIRTH ____/____/____ SSN# _____/_____/_____

INSURED'S EMPLOYER'S NAME _____ ADDRESS _____ OCCUPATION _____

HOME PHONE (____) _____ WORK PHONE #(____) _____ CELL PHONE (____) _____

CLAIMS AND INSURANCE STATEMENT

I AM AWARE THAT I MUST PRESENT MY CURRENT INSURANCE CARD FOR EACH VISIT SO THAT THIS OFFICE MAY BILL MY PRIMARY INSURANCE COMPANY FOR MEDICAL SERVICES RENDERED AS A COURTESY TO ME.

I UNDERSTAND THAT PRESENTATION OF MY INSURANCE CARD IS NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY. CLAIMS ARE SUBJECT TO CURRENT ELIGIBILITY AND BENEFITS REVIEW. **I, THEREFORE, AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES RECEIVED REGARDLESS OF INSURANCE ARRANGEMENTS.**

I AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. JAN T. RYDFORS.

I AGREE THAT CO-PAYMENTS, DEDUCTIBLES AND PAYMENT FOR NON-COVERED SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED.

PATIENT'S SIGNATURE: _____ DATE: _____

EMERGENCY CONTACT

EXCLUDING YOUR SPOUSE - THIS ADDRESS AND TELEPHONE NUMBER MUST BE DIFFERENT THAN YOURS

NAME _____ RELATIONSHIP _____ PHONE (____) _____/_____

ADDRESS _____ ALTERNATE PHONE (____) _____/_____

PHARMACY NAME _____ CITY _____ TEL (____) _____/_____