Obstetrical & Gynecological Associates of Corpus Christi

New Revised
Sh R B H Ch Sc W

Patient is responsible for fees at the time of service.

Address Change Insurance Change Name Change

IMPORTANT - Please complete every blank.

Name:_____ DOB:_____/_____/_____
Last First Middle Initial MM DD YY

Previous Last Name:_____ NickName:_____

SS#:_____-_____-_____ Marital Status: S M D W Sep Other Student Status: F/T P/T N/A

Veteran: Y N Smoker: Y N Race: _____ Language: _____ Religion: _____

Billing Address: _____ _____
Street or P O Box Apt/Unit #

_____ _____ _____
City State Zip Code

Physical Address: _____ _____
Street or P O Box Apt/Unit #

_____ _____ _____
City State Zip Code

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Preferred Contact Method: Home Work Cell Email

PCP:_____ Referred by:_____

Pharmacy:_____ Location:_____

PRIMARY INSURANCE PLAN ID#_____ Group#_____

Insurance Name:_____ Employer Plan? Yes No

Name of Insured:_____ Insured's Employer:_____

Relationship to Patient: _____ Insured's DOB: _____/_____/_____

Insured's Address (If different from patient) _____

Insured's Phone #_____ Insured's SS#: _____/_____/_____

SECONDARY INSURANCE PLAN ID#_____ Group#_____

Insurance Name:_____ Employer Plan? Yes No

Name of Insured:_____ Insured's Employer:_____

Relationship to Patient: _____ Insured's DOB: _____/_____/_____

Insured's Address (If different from patient) _____

Insured's Phone #_____ Insured's SS#: _____/_____/_____

Are you covered by Medicare? Yes No Are you covered by Medicaid? Yes No

Medicare #:_____ Medicaid #_____

If you are under age 18 or someone other than yourself will be the Guarantor on your account:

Guarantor's Name:_____ DOB:_____ Relationship:_____

Guarantor's Address:_____ Phone:_____

How did you find out about our practice?_____

Assignment of Benefits and release of Protected Health Information: I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment directly to Obstetrical & Gynecological Associates of Corpus Christi for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by a third party payer. I hereby authorize Obstetrical & Gynecological Associates of Corpus Christi to release any information contained in my medical record to insurance carriers, treating physicians, or to any institution that will provide treatment and diagnosis to me as necessary regarding my care, to process insurance claims generated in the course of treatment and to allow a photocopy of my signature to be used to process insurance claims for a period of a lifetime unless otherwise revoked by me.

Signed:_____ Date:_____