Patient Information (Confidential)

Welcome to Lifetime Ob/Gyn – Please fill this form out completely

Name

Last:_____ First:_____ Middle:_____

Maiden Name (if applicable):_____ DOB ____/____/_____

Social Security #:_____ Marital Status:_____

Address: (Street)_____

(City)_____ (State)_____ (Zip)_____

Home #:_____ Cell #:_____

Work #:_____ Email:_____

Preferred Mode of Contact: ☐ Home # ☐ Cell # ☐ Work # ☐ Email

Work

Occupation:_____ Employer:_____

Employer's Address:_____ Phone #: _____

Emergency Contact:_____ Relationship _____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

Insurance Information (Please provide ALL medical insurance policies you are covered under)

Primary Insurance Carrier:_____

Identification #:_____ Group #:_____

Insurance Claims Address_____ Phone #:_____

Subscriber Name:_____ Relationship _____

Subscriber SS#:_____ DOB:_____/_____/_____

Subscriber Address:_____

Secondary Insurance Carrier:_____

Identification #:_____ Group #:_____

Insurance Claims Address_____ Phone #:_____

Subscriber Name:_____ Relationship _____

Subscriber SS#:_____ DOB:_____/_____/_____

Subscriber Address:_____

I understand and agree that:

-Failure to complete and give accurate information may result in a delay or a denial of payable benefits and may cause unexpected expenses to me.

-Knowingly or intentionally providing false insurance information may be deemed insurance fraud.

-I will be financially responsible for all deductible, co-insurance, and services not covered by insurance.

I authorize:

-My insurance carrier(s) to make direct payment of medical benefits to the physician for services rendered.

-Release of information to insurance carriers upon request for the purpose of payment of medical services and further treatment or care by another physician.

Patient Signature:_____ Date:_____/_____/_____

Guardian/Responsible Party Name:_____

Gaurdian/Responsible Party Signature:_____

Relationship to Patient:_____