PATIENT INFORMATION

DATE:

Race	Ethnicity

Patient's Name Last First M.I.	Home Phone	Business Phone
Street Address	Date of Birth / Age	Cell Phone
City / State / Zip Code / E-mail	Marital Status ☐S ☐M ☐W ☐D ☐Sep.	Social Security No.
Employer's Name / Employer's Street Address	City / State / Zip Code	
Spouse's Name Last First M.I.	Date of Birth	Social Security No.
Employer (indicate if student)	Cell Phone	Business Phone ( )
Employer's Street Address	City and State	Zip Code
Person Responsible for Payment Last First M.I.	Address	Home Phone
Alternate Contact (someone outside of your home) Last First M.I. / Relationship	Address	Home Phone
Pharmacy Name	Pharmacy Location	

IF PATIENT IS A MINOR OR STUDENT

Mother's Name Last First M.I.	Legal Guardian Yes ☐ No ☐	Street Address, City State and Zip Code		Home Phone
Mother's Employer		Cell Phone	Social Security #	Business Phone
Employer's Street Address		City and State		Zip Code
Father's Name Last First M.I.	Legal Guardian Yes ☐ No ☐	Street Address, City State and Zip Code		Home Phone
Father's Employer		Cell Phone	Social Security #	Business Phone
Employer's Street Address		City and State		Zip Code

INSURANCE INFORMATION

(PLEASE SHOW IDENTIFICATION CARD(s) TO THE RECEPTIONIST)

Primary Insurance Co.	Policyholder Last First M.I.	Date of Birth
Secondary Insurance Co.	Policyholder Last First M.I.	Date of Birth

INSURANCE AUTHORIZATIONS:

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to OB-GYN Associates of Columbus. A copy of this can be considered as an original for insurance purposes.

Signed ______________________________ Date__________

I authorize OB-GYN Associates of Columbus to release any medical information necessary to process insurance claims on my behalf. A copy of this can be considered as an original for insurance purposes.

Signed ______________________________ Date__________

I understand if an outside collection agency is used to collect unpaid patient insurance balances, additional fees may apply.

Signed ______________________________ Date__________