

PATIENT PROFILE

Please print and complete ALL sections below!

Today's Date: _____

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Home Address: _____
(Street) (Apt. #) (City) (State) (Zip Code)

SS#: _____ Marital Status: S M Sep W D DP Spouse/Significant Other: _____

Employer: _____ Occupation: _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Cell Phone: (_____) _____

Best number to call: (_____) _____ May we leave a message? YES NO

Primary Care Doctor (PCP): _____ Phone #: (_____) _____

Pharmacy Name: _____ Phone #: (_____) _____

Pharmacy Address: _____

Email Address: _____ May we use your email for non-medical communication? YES NO

May we use your email to leave you confidential, personal, HIPAA protected information? YES NO

How did you hear about our office? Web Site Radio / TV Newsletter Friend Other _____

GUARANTOR INFORMATION: (Person responsible for payment, if other than self or if patient is a minor)

Person Responsible for Account: _____ Relationship: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: (_____) _____ Business Phone: (_____) _____ Cell Phone: (_____) _____

INSURANCE CARRIER INFORMATION:

Primary Insurance: _____ Eff. Date: _____ Policy#: _____

Billing Address: _____

Insured Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ Eff. Date: _____ Policy#: _____

Billing Address: _____

Insured Name: _____ DOB: _____ Relationship: _____

EMERGENCY CONTACT: Name: _____ Relationship: _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Cell Phone: (_____) _____

PLEASE BE ADVISED THAT YOU MAY RECEIVE SEPARATE BILLS FROM OTHER ORGANIZATIONS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, BIOPSIES AND RADIOLOGY PROCEDURES, AS THEY ARE PERFORMED BY AN OUTSIDE PROVIDER.

Financial Responsibility, Authorization & Consent

I authorize the assignment of insurance benefits to West Ridge Obstetrics & Gynecology, LLP and understand and acknowledge that I am financially responsible for all services rendered to me whether or not they are covered by insurance. For those insurance plans where the practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. This assignment will remain in effect until revoked in writing.

I acknowledge that my account must be kept current and any past due balances are due prior to my next visit. Failure to pay outstanding balances may result in the rescheduling of an appointment. Co-pays and deductibles will be collected at the time services are rendered. I certify that the above information provided by me is correct. I further agree that a photo copy of this agreement shall be as valid as the original. Please be advised there may be an additional charge if any separate issues outside of the normal well woman annual exam are discussed.

If you are unable to keep your scheduled appointment, please notify our office as soon as possible. Failure to give 24 hours notice of a cancellation for an appointment or no-showing of an appointment may result in a charge of \$50 on your account.

I agree to notify West Ridge of a change in my address, guarantor, insurance status, or in my ability to pay for services provided to me as soon as possible.

I consent to the use and disclosure of my confidential health information for the purposes of treatment, payment, and/or practice operations. I give consent to be contacted at all phone numbers provided. This consent will remain in effect until revoked in writing.

Signature of Responsible Party: _____ Date: _____