



How did you hear about West Ridge?

- Radio / TV Newsletter Direct Mail Piece
- Referral from Doctor (which?) _____
- Friend / Relative (who?) _____
- Newspaper / Magazine (which?) _____
- Seminar / Event (what?) _____
- Web Site / Search Engine (which?) _____

PATIENT PROFILE

Please print and complete ALL sections below!

Today's Date: _____
Name: _____ (Last) (First) (Middle) Date of Birth: _____
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
If available, would you prefer to receive appointment reminders by E-mail or U.S. Postal

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

Person Responsible for Account: _____ (Last) (First) (MI) Relationship: _____
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 of person not living with you: _____ 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.

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. This consent will remain in effect until revoked in writing.

Signature of Responsible Party: _____ Date: _____