



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

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.

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: