

PATIENT INFORMATION

Referred By:	Pharmacy #
Name (Last, First, Middle)	
Mailing Address	Street Address
City	State/Zip Code
Home Telephone	Work Telephone
Date of Birth	Age
Marital Status	Cell Phone #
Driver's License	SS#
Employer	Occupation
Telephone	Contact
Spouse's Name	Work Telephone
Spouse's Employer	Spouse's Occupation
Spouse's Date of Birth	Spouse's SS#
If Minor Child: Guarantor's Name	
Mailing Address	Street Address
City/State/Zip Code	City/State/Zip Code
Home Telephone	Work Telephone

INSURANCE INFORMATION

Primary Insurance Carrier	Effective Date
Mailing Address	
City	State/Zip Code
Policyholder's Name	Date of Birth
Relationship to Patient	SS#
Policy/ Subscriber ID#	Group #
Policyholder's Employer	Employer's Telephone
Secondary Insurance Carrier	Effective Date
Mailing Address	
City	State/Zip Code
Policyholder's Name	Date of Birth
Relationship to Patient	SS#
Policy/ Subscriber ID#	Group #
Policyholder's Employer	Employer's Telephone

PAYMENT OR CO-PAYMENT IS DUE AT THE TIME OF SERVICE.
 Payments accepted in the form of **CASH/CHECK/CREDIT CARD.**

- I the undersigned, hereby authorize payment of medical benefits, including Medicare, Medicaid, private insurance and any other health/medical plan, directly to Bay Area OB-GYN, P.A. for services provided to me. I expressly agree and acknowledge that my signature on this document authorizes the physician to submit claims for services rendered and for services to be rendered without obtaining my signature on each and every claim to be submitted for me and/or my dependents, and I will be bound by this signature as though I had personally signed the particular claim.
- I understand that insurance is considered a method of reimbursing the doctor for services rendered and is not considered a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other insurance companies pay only a percentage of the charge. I understand that I am financially responsible for any deductible amount, co-insurance, out of network percentage, and/or any other balance not covered by my insurance.
- I also authorize release to my insurance company information concerning my health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SIGNATURE **DATE**

A photocopy of this assignment shall have the same force and effect as the form bearing the patient's original signature.