Date Advance Directives: YES NO

 If Yes which Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Patient Information |
| Patient Name (Last - First - Middle)Mr. Dr. Ms. Mrs. | GenderM F | Date of Birth | Social Security No.  |
| Address (street - City - State - Zip) | Home Phone No.( ) | Cell Phone No.( ) |
| City, State, Zip | Marital Status Single Married Divorced Widowed | Occupation |
| Email Address | In Case of Emergency, Notify | Emergency Contact’s Phone No.( ) |
| Family Physician  | Family MD Phone No.( ) |
| Employer |  Employer Phone No.( ) |

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| **Insurance Information** |
| **We cannot guarantee insurance coverage by your insurance carrier**. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **Please give your insurance card to our Font Desk to be copied.** |
| Primary Insurance Carrier | ID # | Group # | Social Security No.  |
| Name of Insured | Relationship to Insured | Date of Birth | GenderM F |
| Address (street - City - State - Zip) | Home Phone No.( ) | Work Phone No.( ) |
| City, State, Zip | Employer  | Occupation |
| Secondary Insurance Carrier (if applicable) | ID # | Group # | Social Security No.  |
| Name of Insured | Relationship to Insured | Date of Birth | GenderM F |
| Address (street - City - State - Zip) | Home Phone No.( ) | Work Phone No.( ) |
| City, State, Zip | Employer  | Occupation |

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| **Initial** | **Authorization and Release** |
|  | I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Total Health & Wellness OBGYN LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if for any reason my account is delinquent and turned over to a collection agency I am responsible for the collection agency fees and/or any legal fees. |
|  | I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account. |
|  | **HIPPA DISCLOSURE** I acknowledge that I have been provided a Notice of Privacy Practice Guidelines. |
|  \_\_\_ Patient / Responsible Party Signature Relationship Date |

Total Health and Wellness OBGYN LLC • 4000 Miamisburg-Centerville Road, Suite 104 • Miamisburg, Ohio 45342 • 937.384.8780 • info@drrozmd.com • [www.drrozmd.com](http://www.drrozmd.com)