Date Advance Directives: YES NO

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Information | | | | | |
| Patient Name (Last - First - Middle)  Mr. Dr. Ms. Mrs. | | Gender  M 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.  ( ) | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | Gender  M 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 | | | Gender  M 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](mailto:info@drrozmd.com) • [www.drrozmd.com](http://www.drrozmd.com)