WEST KENDALL OBGYN

Last Name/Apellido_______________________ **First Name/Nombre**____________________ **M.I**_______

Social Security Number___________________ **DOB/Fecha de Nacimiento**__________________________

Home Address/Dirección____ **City**____________ **State**____

Zip Code/Código Postal______________ **Email**____

Home Phone/Teléfono_________________**Work/Trabajo**_______________ **Mobile**____________________

Marital Status/Estado Civil_____________ **Race/Raza**_____________ **Ethnicity/Origen Étnico**___________

PRIMARY DR. / MEDICO PRIMARIO:______________________________**Phone/Telefono**______________

Name & Phone Number of an Emergency Contact
Nombre y Teléfono de un Contacto de Emergencia:____

Pharmacy/Farmacia_____________________________________**Phone/Telefono**__________________

Pharmacy Location/Dirección de Farmacia____

Primary Insurance/ Seguro Primario____

Member ID/Numero de Membrecía_________________________**Group #/Numero de Grupo**_______________

Insurance Billing Address/Dirección de Seugro____

Insurance Phone Number/Teléfono de Seguro____

Name of Insured/Nombre de Asegurado________________________**SS#**_________________________________

DOB/Fecha de Nacimiento______________ **Relationship to Patient/Relación con el Paciente**_________________

***PLEASE READ:** **ALL charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claims forms to the office prior to hospitalization.**

I hereby authorize payment of medical benefits billed to my insurance by Florida Woman Care. I hereby accept responsibility for payment of any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the practice does not participate with my insurance. I agree to pay all co-payments, co-insurance, and deductibles at the time that services are rendered.

Signature/Firma_______________________________________ **Date/Fecha**__________________________