FemmPro OB/GYN DATE: _____

PATIENT INFORMATION

NAME: _____
LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

ADDRESS: _____ **HOME PHONE:** (____) _____
STREET CITY/STATE ZIP CODE

E-MAIL_____ **CELL PHONE:** (____) _____

BIRTHDATE: ____/____/____ **AGE:** _____ **MARITAL STATUS:** S M W D *(CIRCLE ONE)* **SOCIAL SECURITY NO.** ____/____/____

EMPLOYED BY: _____ **OCCUPATION:** _____

ADDRESS: _____ **WORK PHONE:** (____) _____
STREET CITY/STATE ZIP CODE

SPOUSE NAME: _____ **DOB** ___/___/____

EMPLOYED BY: _____ **WORK PHONE:** (____) _____

IN CASE OF EMERGENCY, CONTACT: _____ **PHONE:** (____) _____

REFERRED BY: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ **PHONE:** (____) _____

INFORMATION ON PERSON RESPONSIBLE FOR BILL

GUARANTOR NAME: _____
LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

ADDRESS: _____ **HOME PHONE:** (____) _____
STREET CITY/STATE ZIP CODE

WORK PHONE: (____) _____

SOCIAL SECURITY NO. ____/____/____ **RELATIONSHIP TO PATIENT:** _____

EMPLOYED BY: _____ **HOW LONG:** _____ **OCCUPATION:** _____

INSURANCE INFORMATION

Do you have insurance to cover the FEES for services rendered? € Yes € No

PRIMARY INSURANCE

COMPANY: _____
ADDRESS: _____
_____
PHONE #: (___) _____ INSURED DOB: ___/___/____
ID #: _____ GRP #: _____

SECONDARY INSURANCE

COMPANY: _____
ADDRESS: _____
_____
PHONE #: (___) _____ INSURED DOB: ___/___/____
ID #: _____ GRP #: _____

I authorize payment of medical benefits to *Femm Pro* OB/GYN for services rendered as described. I understand I am legally responsible for full payment such services regardless of insurance coverage.

_____ _____
SIGNATURE OF INSURED **DATE**

I authorize the release of all medical information to Medicare. which is necessary to process this claim. Additionally, I request payment of my Medicare benefits to myself or the party who accepts assignment. I also request the assignment of my Medicare benefits to *FemmPro* OB/GYN. in payment of this claim.

_____ _____
SIGNATURE OF INSURED **DATE**