WOODGLEN OB/GYN MEDICAL GROUP

Patient Information (Please Print)

Name _____

Address _____

City/St/Zip _____

Social Security Number _____

Date of Birth ____/____/____

Phone: Home / Work / Cell :_____

Phone: Home / Work / Cell :_____

Phone: Home / Work / Cell :_____

Drivers Lic. _____

Occupation/Student _____

Employer/School _____

Referred by_____

Marital Status: Single Married Divorced Widowed Partner

E-Mail Address _____

Responsible Party Information

Name _____

Address _____

City/St/Zip _____

Social Security Number _____

Date of Birth ____/____/____

Phone: Home / Work / Cell :_____

Phone: Home / Work / Cell :_____

Relationship to Patient

☐ Spouse ☐ Parent ☐ Legal Guardian

☐ Other_____

Insurance Information

Insuance Carrier_____

Insurance I.D. # _____

Subscriber's Name _____

Subscriber's Date of Birth: _____/_____/_____

Additional Insurance ☐ Yes ☐ No

Insuance Carrier_____

Insurance I.D. # _____

Subscriber's Name _____

Subscriber's Date of Birth: _____/_____/_____

Emergency Contact

Name _____

Phone: Home / Work / Cell : _____

Phone: Home / Work / Cell : _____

Phone: Home / Work / Cell : _____

Relationship to Patient

☐ Spouse ☐ Parent ☐ Legal Guardian

☐ Other_____

What is your principle language:_____

☐ ***Alternate mailing address:*** _____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO Woodglen OB/GYN MEDICAL GROUP, ALL SURGICAL AND / OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE. I HEREBY AUTHORIZE YOU TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE INSURANCE / HEALTH PLAN

SIGNATURE_____ DATE_____

(IF THE PATIENT IS A MINOR, SIGNATURE OF PARENT OF GUARDIAN AUTHORIZING TREATMENT)

GENERAL CONSENT: I HEREBY CONSENT TO ALL MEDICAL TREATMENTS, DIAGNOSTIC TESTING OR PROCEDURES DEEMED ADVISABLE BY MY PHYSICIAN AT WOODGLEN MEDICAL GROUP. I HAVE READ AND UNDERSTAND THIS CONSENT.

SIGNATURE_____ DATE_____

(IF THE PATIENT IS A MINOR, SIGNATURE OF PARENT OF GUARDIAN AUTHORIZING TREATMENT)

****NOTE: Please notify us if any of the above information changes during the course of treatment***