CONFIDENTIAL PATIENT INFORMATION SHEET

LAST NAME		**FIRST NAME**	**M.I.**
DATE OF BIRTH		**SOCIAL SECURITY NUMBER:**	
Race/Ethnicity (circle): Asian/Pacific Islander Black White Hispanic Other		**Marital Status** (circle): Single Married Divorced Widowed	
ADDRESS	**Apt/Unit**	**CITY/STATE**	**ZIP**
What is your primary phone number? (circle) Home Work Cell		**E-MAIL**	
PHONE (Home)	**PHONE (Work)**	**PHONE (Cell)**	

EMERGENCY CONTACT INFORMATION		
NAME	**PHONE**	**RELATIONSHIP:** □ Spouse □ Parent □ Other

PRIMARY INSURANCE INFORMATION			
INSURANCE COMPANY NAME		**Phone**	
ADDRESS		**CITY/STATE**	**ZIP**
EMPLOYER NAME	**Insurance ID #**	**Plan/Group #**	
If you are covered as a dependent, please complete this section with the person who carries the insurance			
RELATIONSHIP: □ Spouse □ Parent □ Other		**GENDER:** □ Male □ Female	
LAST NAME		**FIRST NAME**	
DATE OF BIRTH		**SOCIAL SECURITY NUMBER**	
ADDRESS	**Apt/Unit**	**CITY/STATE**	**ZIP**

SECONDARY INSURANCE INFORMATION			
INSURANCE COMPANY NAME		**Phone**	
ADDRESS		**CITY/STATE**	**ZIP**
EMPLOYER NAME	**Insurance ID #**	**Plan/Group #**	
If you are covered as a dependent, please complete this section with the person who carries the insurance			
RELATIONSHIP: □ Spouse □ Parent □ Other		**GENDER:** □ Male □ Female	
LAST NAME		**FIRST NAME**	
DATE OF BIRTH		**SOCIAL SECURITY NUMBER**	
ADDRESS	**Apt/Unit**	**CITY/STATE**	**ZIP**

PREFERRED PHARMACY INFORMATION		
PHARMACY NAME	**Phone**	
ADDRESS	**CITY/STATE**	**ZIP**

CONFIDENTIAL PATIENT INFORMATION SHEET

Authorization to File Insurance Claim and Financial Responsibilities:

I hereby authorize payment of insurance benefits to TriState OB/GYN and any assisting physicians for services rendered. I understand that I am financially responsible for payment of any charges that are not covered by my insurance company; including co-payments, deductibles, co-insurance and any service denied as non-covered or denies for any other reason by my insurance company. In the event of default, I will be held responsible for payment of all collection costs and an associated attorney fees.

Use of Protected Health Information (PHI)

I understand that my protected health information will be shared for the purpose of treatment, payment and any health-care related operations. By my signature below, I authorize the release of my protected health information. I agree that a photocopy of my signature shall be as valid as the original.

Laboratory and Pathology Services

Laboratory and Pathology services are not rendered at our facility; blood and/or tissue specimens will be sent to the laboratory or pathology company for evaluation and reporting. These services will be billed by the individual laboratory or pathologist and are NOT included in our fees. I understand that I may be financially responsible for payment of such services in addition to the services rendered by TriState OB/GYN.

PATIENT (OR RESPONSIBLE PARTY) SIGNATURE	**DATE**