

MY PHARMACY IS:
Name: _____
Location: _____
Phone #: _____

Generations ObGyn
PATIENT INFORMATION RECORD

BLACK INK ONLY

Home Phone _____ Cell Phone _____

Date _____ Email _____

Patient Name(legal) _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ SS# _____ Marital Status _____ Full Time Student _____

Occupation _____ Employer/School _____ Phone _____

Spouse Name _____ Employer _____ Phone _____

Spouse Birthdate _____ SS# _____

Race _____ Preferred Language _____ Ethnicity _____

Notify In Emergency _____ Phone _____ Relationship _____

Referred By _____

Financial Responsibility (if different than above)

Name _____ Birthdate _____ Phone _____ SS# _____

Address _____ City _____ State _____ Zip _____

Employer _____ Phone _____ Relationship to Patient _____

INSURANCE----PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier _____ Effective Date _____

Insurance Address _____

ID# _____ Group# _____

Subscriber's Name _____ SS# _____ Birthdate _____

Secondary Insurance Carrier _____ Effective Date _____

Insurance Address _____

ID# _____ Group# _____

Subscriber's Name _____ SS# _____ Birthdate _____

INITIAL

- _____ I consent to treatment necessary for the care of the above named patient.
- _____ I authorize the release of all medical records to the referring or treating physicians and to my insurance company, if applicable.
- _____ I allow fax transmittal of my medical records if necessary.
- _____ I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- _____ If this account becomes past due, I agree to pay all reasonable collection costs. If legal action is required to collect this account, I agree to pay all attorney fees and court costs.
- _____ I further authorize and request that insurance payments be made directly to Generations ObGyn PC., should they elect to receive such payment.
- _____ I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

SIGNATURE: _____ DATE _____