

WELCOME TO RIVER ROSE OBSTETRICS & GYNECOLOGY

Patient Information

Date: _____

Patient: _____

Address: _____

City _____ State _____ Zip _____

Age: _____ Birthdate: _____

Marital Status: _____

Social Security # _____

(If patient is a minor, guardian's SS# or DL# - No Exceptions)

Parent/Guardian SS#: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS#: _____

Spouse's Employer: _____

How did you hear about us? Spouse Friend

Newspaper Yellow Pages Other _____

If referred by Doctor whom may we thank?

PHONE NUMBERS

Home: _____ Work: _____ Ext _____

Cell Phone: _____ Other: _____

Best time and place to reach you _____

In Case of Emergency, Contact

Name: _____

Relationship: _____ Phone# _____

Insurance Information

Insurance Company: _____

Subscriber Name: _____

ID# _____

Relationship to Patient? _____

Birthdate: _____ SS# _____

Is patient covered by additional insurance? Y ___ N ___

Assignment and Release

I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to River Rose OB/GYN (Athens Medical Associates) all insurance 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to River Rose OB/GYN (Athens Medical Associates) for any services furnished me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are abased upon the charge determination of the Medicare carrier.

Signature

Date

