Marietta OB-Gyn Affiliates, P.A.

IT IS YOUR RESPONSIBILITY TO PRESENT YOUR INSURANCE CARD AT EVERY VISIT AND NOTIFY US OF *ANY* CHANGE, INCLUDING YOUR PRIMARY CARE PHYSICIAN.

Patient Information

Name____
Street Address___________________________________
City__________________________ State____________
Zip Code____
Employer / School ________________________________
Street Address___________________________________
City______________________ State________________
Zip Code____

Home Phone______________________________________
Work Phone ______________________________________
Cell Phone _______________________________________
Date of Birth _____________________________________
Social Sec.# ______________________________________
Marital Status ☐ Single ☐ Married
Primary Care Physician ____________________________
Referred by _______________________________________

Occupation ____

Insurance Information

Name of Primary Insurance Company______________________________ Group #______________________
ID #______________________________ Co-Pay(Specialist)/Deductible______________________________
Name of Policy Holder____ Sex: Male _____ Female _____
Date of Birth______________________ Street Address____
City _________________________ State _____ Zip ________ Social Sec. # of Insured ____________________
Home Phone# ______________________ Insured's Employer ____________________________________
Relationship of Patient to Insured : Self_____ Wife _____ Child _____

Name of Secondary Insurance Company______________________________ Group #______________________
ID #______________________________ Co-Pay(Specialist)/Deductible______________________________
Name of Policy Holder____ Sex: Male _____ Female _____
Date of Birth______________________ Street Address____
City _________________________ State _____ Zip ________ Social Sec. # of Insured ____________________
Home Phone# ______________________ Insured's Employer ____________________________________
Relationship of Patient to Insured : Self_____ Wife _____ Child _____

Emergency Contact: Husband, Parent, if Patient is a Minor, or Closest Relative

Name____ Relationship to Patient ___________________________
Street Address_________________________________ City ____
State ____ Zip ____________ Home Phone_____________________
Work Phone_____________________________________ Cell Phone _______________________________________

AUTHORIZATION TO RELEASE INFORMATION: I authorize Marietta OB-Gyn Affiliates, P.A., to release any information regarding my examination or treatment, for purpose of obtaining insurance compensation, precertification, referrals, prior authorization, coordination of care with other Health Care Providers, insurance carrier for quality assurance, and permission for Marietta OB-Gyn Affiliates to file a complaint with the Insurance commissioner.

Signature ____________________________________ Date______________________________

AUTHORIZATION TO PAY: I authorize payment of medical benefits to Marietta OB-Gyn Affiliates, P.A. I understand that I am financially responsible for the billing charges, "NON COVERED" services not paid by insurance and services denied from providing incorrect insurance information.

Signature ____________________________________ Date______________________________