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 o Single o 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 if Patient is a Minor

Name of Parent_____ Relationship to Minor 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 billing charges, missed appointment fees, "NON COVERED" services not paid by insurance and services denied from providing incorrect insurance information.

Signature _____ Date_____