Marietta OB-Gyn Affiliates, P.A.

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

Name ______ Street Address ______ City ______ State ______ Zip ______	Home Phone ______ Work Phone ______ Cell Phone ______ Date of Birth ______
Employer/School ______ Street Address ______ City ______ State ______ Zip ______	Social Security# ______ Marital Status ○ Single ○ Married Primary Care Physician ______ Referred by ______

Insurance Information

Primary Insurance Company ______ Name of Policy Holder ______ Street Address ______ City ______ State ______ Zip ______ Insured's Employer ______ Relationship of Patient to Insured: Self ______ Wife ______ Child ______	Group# ______ ID# ______ Date of Birth ______ Sex: Male ______ Female ______ Social Security # of Insured ______ Home Phone # ______
Secondary Insurance Company ______ Name of Policy Holder ______ Street Address ______ City ______ State ______ Zip ______ Insured's Employer ______ Relationship of Patient to Insured: Self ______ Wife ______ Child ______	Group# ______ ID# ______ Date of Birth ______ Sex: Male ______ Female ______ Social Security # of Insured ______ Home Phone # ______

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

Name ______ Street Address ______ City ______ State ______ Zip ______ Relationship to patient ______	Home Phone ______ Work Phone ______ Cell Phone ______

Medical information and/or test results

Name ______ Home Phone ______ Work Phone ______ Cell Phone ______	______ Given to PATIENT ONLY Given to the following person(s) ______ ______

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.

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 ______________

Revised 6/6/2019