PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: ___ / _____ / _____ SSN: _____

PATIENT ADDRESS: _____ CITY: _____ STATE: __ ZIP: _____

☐ HOME PHONE: _____ ☐ WORK PHONE: _____

☐ CELL PHONE: _____ ☐ EMAIL: _____

(Please check the box to indicate your preferred means of communication)

EMPLOYER: _____ MARITAL STATUS: _____

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN

☐ HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ UNKNOWN ☐ DECLINED

ETHNICITY: ☐ DECLINED ☐HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐UNKNOWN

PHARMACY PREFERRED: _____ PHARMACY LOCATION: _____

REFERRING DOCTOR: _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ OTHER PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DATE OF BIRTH: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

SECONDARY INSURANCE INFORMATION PLAN NAME: _____

POLICY HOLDER: _____ DATE OF BIRTH: _____ EFFECTIVE DATE: _____

INSURANCE ID #: _____ GROUP #: _____ PLAN #: _____

ASSIGNMENT AND RELEASE OF BENEFITS

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to Southern Illinois OB-GYN Assoc., S.C. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I agree to pay a 30% collection fee, 20% legal fee (if legal action taken), attorney fees and court costs incurred by Southern Illinois OB-GYN Associates, S.C. in the collection of amounts for which I am responsible. I also authorize you to release to my insurance company information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

MEDICARE LIFETIME SIGNATURE ON FILE: WE DO NOT ACCEPT MEDICARE ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf of Southern Illinois OB-GYN Associates, S.C. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Signature: _____ **Date:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Our practice is committed to securing the privacy of your health information. We have posted our practice's Notice of Privacy in the reception area. You are not required to read this Notice, however we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Signature of Patient_____ Date: _____