DATE _____

NAME _____

(PLEASE PRINT)

PLEASE TELL US THE REASON FOR YOUR VISIT TODAY _____

_____

Your insurance will be billed accordingly with the proper procedure and diagnosis codes. We are unable to change any codes after the insurance is filed.

SIGNATURE _____

**PLEASE NOTE: THERE WILL BE A SEPARATE CHARGE FROM THE LABORATORY FOR ANY SPECIMENS SENT FROM THIS OFFICE. *ie: Pap Smears, biopsies and cultures*

PLEASE PRINT

Patient Registration

Date _____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information

Social Security # _____

First Name _____ Middle _____

Last Name _____

Sex _____ Date of Birth _____ / _____ / _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race/Ethnicity _____

☐ Employed ☐ Retired ☐ Full-Time Student ☐ Other _____

Employer _____

Address _____
Street City State Zip

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____

Cell Phone (_____) _____

Preferred Phone ☐ Home ☐ Cell OK to leave message? Y / N

I was referred by: _____

Work Phone (_____) _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

Primary Insurance Information

Please fill in your insurance information below

☐ Commercial ☐ Medicare ☐ Other _____

Insurance company _____

Insured / Card Holder's Name _____ Date of Birth _____ / _____ / _____ Relationship _____

Policy # _____ Group # _____ Phone (_____) _____

Employer _____

Subscriber's Address: _____
Street City State Zip

Secondary Insurance Information

☐ Commercial ☐ Medicare ☐ Other _____

Insurance company _____

Insured / Card Holder's Name _____ Date of Birth _____ / _____ / _____ Relationship _____

Policy # _____ Group # _____ Phone (_____) _____

Employer _____

Subscriber's Address: _____
Street City State Zip

Spouse / Guarantor / Responsible Party

Social Security # _____

Relationship _____

First Name _____ Middle _____

Last Name _____

Address _____

City _____ State _____ Zip _____

Sex _____ Date of Birth _____ / _____ / _____

Daytime Phone (_____) _____

Employer _____

Address _____

City _____ State _____ Zip _____

Signature Required Please See Reverse Side

09/15

John A. White, M.D.
Obstetrics and Gynecology
533 North Clyde Morris Boulevard
Daytona Beach, Florida 32114
(386) 255-0901

WITH WHOM MAY WE DISCLOSE ANY OF YOUR MEDICAL INFORMATION.
(Future appointments, test results, medical status, billing)

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

X_____**DATE:**_____

We are part of a large group of doctors **Vital MD Group Holding, LLC**. Your insurance will send all payments and Explanation of Benefits for services rendered in this office to **Vital MD Group Holding, LLC**, in Miami, Florida. Our office **does not receive checks or explanations** from your insurance company.

If there is any discrepancy on the bill you receive from this office regarding insurance payments and adjustments, we ask that you send us a copy of the Explanation of Benefits you receive from your insurance company so we may make sure your account is properly credited.

X_____

Due to insurance purposes, have you seen any of the doctors, listed below, since 2011.
Please circle.

Desai Robertson Tapia Bagwell Haddox

Vagovic

Meyers DaSilva Gilmore

Dr. Whitney Shoemaker

Medication and Doctor List

Please list ALL medications you currently are taking, prescription & over the counter, including dosage.

	Name of Medication	Name of Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Insurance policy – John A. White, MD, Obstetrics and Gynecology, LLC

If the insurance information I provide to John A. White, MD, Obstetrics and Gynecology, LLC is incorrect and I do not provide the correct insurance information in a timely manner, I understand that I will be responsible for all charges for all services rendered to me.

I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed Date

John A. White, M.D., L.L.C.
Office Policies and Consent
****Initial after each Policy & Consent.****

1. **Insurance Benefits:** Payment is expected at the time of service. This includes copays, co-insurance, and any remaining deductibles. **Please note,** all benefit information is provided to us by your insurance company. If there are any discrepancies with your benefits, we ask that **you** contact your insurance company. _____**initial.**

2. **Financial Responsibility:** Upon checking in, our staff will inform you of your financial obligation for your appointment as well as any past due balances. Payment at this time will be requested. _____ **initial.**

3. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. These arrangements must be made with our billing/insurance department. If you have not made a financial arrangement and/or have not made an attempt to pay your obligation, your account will be placed in a collection status. Your account will be turned over by the practice to a debt collector. A fee, in the amount of **35% of the total amount due,** will be added to your outstanding balance. _____ **initial.**

4. **No Show Policy:** Our office enforces a "No Show" policy. We ask that if you must cancel your appointment that you kindly give us a 24-hour notice. **New Patient Appointment** "no show" fee is $50.00. **Established Patient appointments** "No Show" fee is $50.00. The "No Show" fee is required to be paid before another appointment can be scheduled. _____ **initial.**

5. **Surgical fees:** At the time your procedure/surgery is scheduled, our office will notify you your estimated financial obligation. Your obligation is expected to be paid no later than your pre-op visit. Failure to pay your portion may result in your procedure/surgery being rescheduled. _____ **initial.**

6. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you are submitting your own claim, you will be given the information needed when you check out to forward to your insurance company. _____ **initial.**

7. **Medical Records:** There is a $1.00 per page fee for the first 25 pages, and $0.25 for each additional page. Allow 72 hours for your request to be fulfilled. Medical Record requests can be printed from our website. _____ **initial.**

8. **Consent:** I hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This consent will remain Active until I withdraw my consent in writing. _____ **initial.**

I certify that I have read and understand the above office policies and Consent.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Printed Name Patient DOB