SOUTH LAKE OB/GYN & ADVANCED SURGERY

NEW PATIENT REGISTRATION/ NEW INSURANCE INFORMATION

PATIENT INFORMATION:

PATIENT NAME: ____AGE:_________________________________

ADDRESS: ____

____

DOB: ______________________ SSN: ____

HOW WOULD YOU PREFER TO BE CONTACTED?

PHONE: ____ CELL: _____________________________________ EMAIL: ______________________________

HOW DID YOU HEAR ABOUT SOUTH LAKE OB/GYN AND ADVANCED SURGERY? (PLEASE CIRCLE ALL THAT APPLY):

FAMILY: FRIEND: INSURANCE: GOOGLE: FACEBOOK:

INSTAGRAM: EVENT: PCP: PHYSICIAN OTHER:

DOCTOR OR PERSON WHO REFERRED YOU: ____ MAY WE THANK THIS PERSON? ____________________

PATIENT EMPLOYER:

PATIENT EMPLOYER: ____ OCCUPATION: _______________________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ____

ID#:____ GROUP#:____

POLICY HOLDER: _________________________________ RELATIONSHIP: ____

SSN: ____ DOB: ___________________________ EMPLOYER NAME: _______________________________

SECONDARY INSURANCE: ____

ID#:____ GROUP#:____

POLICY HOLDER: _________________________________ RELATIONSHIP: ____

SSN: ____ DOB: ___________________________ EMPLOYER NAME: _______________________________

PRIMARY CARE PHYSICIAN: ____ PHONE: _______________________________________

PHARMACY INFORMATION: ____PHONE:____

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign to ***South Lake OB/GYN & Advanced Surgery*** to any insurance or third party benefits available for health care services provided to me. I authorize the release of medical information necessary to process medical insurance companies of their agencies (including Medicare), for the purpose of filing and payment of medical claims. If these benefits are not assigned to ***South Lake OB/GYN & Advanced Surgery***, I agree to forward to the practice all health insurance and other third party payments I receive for services rendered to me immediately upon receipt. I recognize that I am financially responsible for all services rendered to the above named patient regardless of insurance coverage. By signing this form, I agree to assign all health insurance benefits to ***South Lake OB/GYN & Advanced Surgery*** and to be financially responsible for any co-pays, co-insurance, deductibles, and non-covered fees at the time of service.

PATIENT OR RESPONSIBLE PARTY: ____DATE: _________________________________