

UNIVERSITY PARK OBSTETRICS AND GYNECOLOGY, LLC -SHAWN STEPHENS, M.D.

(Please Print)		Today's Date: / /	
Patient's last name:		First:	Middle:
Birth date: / /	Age:	Marital status (circle one)	Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?	
Street address:		P. O. Box:	Email Address:
City:	State:	ZIP Code:	SS#:
Cell Phone:	Home Phone:	Work Phone:	
Occupation:	Employer:		
How did you hear about our office?		<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other Describe:
Race: <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other			
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non Hispanic or Latino Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Preferred Pharmacy:		Location:	Phone:
INSURANCE INFORMATION			
(Please give your insurance card and photo identification to the receptionist.)			
Please indicate primary insurance:			
Insurance ID#:		Group #:	Co-pay: \$
Subscriber's name:			Subscriber's Birth date: / /
Subscriber's S.S. #:	Patient's relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of secondary insurance:		Subscriber's name:	
Group #:		Policy #:	
IN CASE OF EMERGENCY			
Name of local friend or relative to contact:			
Home phone #:	Work phone #:	Relationship to patient:	
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION			
May we call you on your cell?	Yes No	May we send a yearly recall to your home?	Yes No
May we leave a message on your cell ?	Yes No	May we call you at work?	Yes No
I authorize University OBGYN to speak with _____ regarding my healthcare/PHI . (relationship to you) _____ Phone Number # _____			
I acknowledge and agree to adhere to the Notice of Privacy Practices as required by federal and state guidelines. I have been provided a copy of the Notice of Privacy Practice and understand that I may request and review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.			
Patient/Guardian signature			Date
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION			
I have completed this form and certify that I am the patient or duly authorized agent of the patient. I authorize the providers of University Obstetrics and Gynecology, LLC to provide medical care and treatment for me. I understand Medical Treatment may include a Medically indicated examination including but not limited to a Pelvic Exam. I authorize University Obstetrics and Gynecology, LLC to obtain verification of my medication/prescription history in order to provide continuity of care. I authorize release of my medical information as directed by my physician for outside referrals to specialists, hospitals, laboratories and others as necessary for my continued care.			
I hereby authorize payment of benefits to be made directly to University Obstetrics and Gynecology, LLC and/or any of the providers individually. I understand, as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. I understand that any overpayment I make will be refunded if the credit amount is over \$20.00, otherwise, the credit will be held for 18 months for future balances unless a request for refund is received.			
Patient/Guardian signature			Date