New Beginnings Ob/Gyn, PC –

PATIENT INFORMATION SHEET

Patient Name: _____ Social Security No: _____
(**Please Print**) Last First MI

Present Address: _____
House Number and Street City State Zip Code

Permanent Address: _____
House Number and Street City State Zip Code

Phone: Home: _____ Work: _____ Cell: _____

Date of Birth: ____ - ____ - ____ Age: _____ Race: _____ Marital Status: M S D W SEP
Month - Day - Year

Employer: _____ Occupation: _____ How Long: _____

Responsible Party Information - Where do statements get sent if different from info listed above

Name of Spouse/Parent: _____ Social Security : _____

Relationship to Patient: _____ Date of Birth: ____ - ____ - ____ Phone: _____
Month - Day - Year

Address: _____
House Number and Street City State Zip Code

Employer: _____ Phone: _____

Insurance Information: *Primary Insurance Carrier*: _____

Subscriber: _____ Subscriber SSN: _____

Policy Number: _____ Effective Date: _____

Group Number: _____ Subscriber Date of Birth: : ____ - ____ - ____
Month - Day - Year

Employer: _____ Phone: _____

Secondary Carrier Info:
Secondary Insurance Carrier: _____ ID Number: _____

Group Number: _____ Subscriber Name: _____

Subscriber SSN: _____ Subscriber DOB: ____ - ____ - ____
Month - Day - Year

EMERGENCY CONTACT: Name: _____ Phone: _____

Address: _____
House Number and Street City State Zip Code

Who referred you to Brenda J. Hines, MD? _____ **Primary Care Dr:** _____

Financial Agreement and Authorization for Treatment: I authorize treatment for the above registered patient and authorize New Beginnings Ob/Gyn, PC to furnish information to insurance carriers concerning my illness and treatments. I agree to pay all charges promptly. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable. If my account becomes assigned to a collection agency, I agree to pay all cost of collections, including any agency fees and/or court costs and reasonable attorney fees. I further understand that all accounts with a balance over 30 days will be assessed a 1% interest charge per month. 12% per year.

Signature or patient or legal guardian: _____ Date: _____
Relationship to patient: _____ Phone Number: _____