NEW PATIENT AND INSURANCE INFORMATION

**PATIENT INFORMATION**:
PT NAME:_____
PT. ADDRESS:_____
DOB:_____SS#:_____
PHONE: _____CELL:_____
E-MAIL:_____
**EMPLOYMENT INFORMATION**:

PLACE OF EMPOLYMENT:_____
WORK PHONE #:_____

**INSURANCE INFORMATION**:

INSURANCE COMPANY:_____
HMO PPO EPO POS OTHER
EFFECTIVE DATE OF POLICY:_____
CLAIMSADDRESS:_____
INSURANCE TELEPHONE:_____
POLICY #:_____GROUP #:_____
PRIMARY INSURED NAME:_____
PRIMARY INSURED DOB:_____SS#:_____

**IF HMO NAME OF YOUR PRIMARY CARE PHYSICIAN**:
DR._____
PHONE:_____

**ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY**

I hereby assign to South Lake OB/GYN & Advanced Surgery any insurance or other third party benefits available for health care service provided to me. I authorize the release of medical information necessary to process 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 that 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-payments, deductibles and non-covered fees at the time of service.

Patient or Responsible Party:_____ Date:_____