O B • G Y N
HEALTH CENTER
Daytona Beach, FL

PATIENT INFORMATION

Social Security # _____ Age _____

Patient Name _____ Today's Date _____

Mailing Address _____

City/State/Zip Code _____

Birthdate _____ Marital Status _____

Home Phone _____ Cell Phone _____Work Phone _____

Employer _____

Employer Address _____

INSURANCE INFORMATION AND/OR RESPONSIBLE PARTY

Primary Insurance _____ Policy # _____ Group #_____

Subscriber's Name _____

Subscriber's Employer _____

Birthdate _____ Social Security # _____

Secondary Insurance _____ Policy # _____ Group #_____

IN CASE OF EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____Work Phone _____

REFERRAL INFORMATION

How did you hear about us? (Please select one option)

___ A friend/family member ___ Internet Search ___ I was referred by Dr. _____
___ Other _____

LIFETIME SIGNATURE AUTHORIZATION

I authorize the release of any medical information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment.

I understand payment is due when services are rendered. Pap smears and lab charges are not included in the office visit fee.

_____ _____

Patient Signature Date