OBSTETRIX MEDICAL GROUP

PATIENT REGISTRATION FORM

Account #_____

GENERAL INFORMATION

PATIENT INFORMATION

How well do you speak English? ___ Very Well ___ Well ___ Not Well ___ Not At All

Name (First, M.I., Last): _____ DOB: _____/ _____/ _____

Mailing Address: _____ Apt # :_____ Cell #: ( ) _____

City, State, Zip Code: _____ Phone #: ( ) _____

Social Security # _____/ _____/ _____ Marital Status: (Please circle) Single Married Divorced Widowed

Patient's Employer: _____ Work #: ( ) _____

SPOUSE/GUARDIAN INFORMATION

Name: _____ DOB: _____/ _____/ _____

Social Security # _____/ _____/ _____ Relationship to Patient: _____

Employer: _____ Work #: ( ) _____

Nearest relative NOT at your address: _____

Street Address, City, State, Zip: _____

Phone #: ( ) _____ Relationship to patient: _____

REFERRING PHYSICIAN INFORMATION

Dr.'s Name:(First)_____ (Last)_____ Specialty:(i.e. OBGYN/PCP)_____

Street Address, City, State, Zip: _____

Phone #: ( ) _____ Fax #: ( ) _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Company: _____ HMO___ PPO___ POS___ EPO___ OTHER___

Insurance Company Telephone Number: ( ) _____ Effective date: _____

Insured: _____ DOB: _____ Relationship to Patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: ( ) _____

Secondary Insurance Information

Name of Company: _____ HMO___ PPO___ POS___ EPO___ OTHER___

Insurance Company Telephone Number: ( ) _____ Effective date: _____

Insured: _____ Relationship to Patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: ( ) _____

PATIENT RESPONSIBILITY

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize Obstetrix Medical Group of Texas to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services whether or not covered by insurance.

SIGNATURE: _____ DATE: _____