PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

EMPLOYMENT STATUS (circle one) FULL TIME PART TIME RETIRED SELF EMPLOYED NOT EMPLOYED MILITARY ACTIVE STUDENT: FULL OR PART MARITAL STATUS: M S W D

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____

RELIGION _____ PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATION TO PATIENT _____ PHONE _____

GUARANTORS/SPOUSE INFORMATION

GUARANTOR/SPOUSE NAME _____ GUARANTOR/SPOUSE DATE OF BIRTH _____

ADDRESS (IF DIFFERENT FROM PATIENT'S) _____

GUARANTORS/SPOUSE S.S.# _____ GUARANTOR/SPOUSE LICENSE # _____

GUARANTORS/SPOUSE EMPLOYER _____ PHONE _____

RELATIONSHIP TO PATIENT (please circle one) HUSBAND WIFE PARENT LEGAL GUARDIAN OTHER _____

PERSON RESPONSIBLE FOR THE BILL _____

PLEASE CHECK ONE OF THE FOLLOWING METHODS OF PAYMENT:

❑ CASH ❑ PRIVATE INSURANCE ❑ MEDICARE ❑ MEDICAID ❑ CREDIT CARD ❑ VISA ❑ MASTERCARD ❑ AMERICAN EXPRESS

INSURANCE CARRIER NAME _____

ADDRESS _____

_____

INSURED NAME _____

POLICY # _____

INSURED D.O.B. _____

GROUP NAME _____

INSURANCE CARIER NAME _____

ADDRESS _____

_____

INSURED NAME _____

POLICY # _____

INSURED D.O.B. _____

GROUP NAME _____

WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE, MEDICARE AND/OR MEDICAID

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. DO NOT HESITATE TO SPEAK WITH US NOW IF THIS IS A PROBLEM.

AUTHORIZATION TO RELEASE INFORMATION

Biloxi OBGYN may disclose all or part of this patient's record to any insurance company or association, the Federal State Government such Information as may be necessary for the completion of all Clinic claims.

I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse. A copy shall be as valid as the original.

ASSIGNMENTS OF BENEFITS

I hereby authorized the above-listed insurance companies to pay directly to Biloxi OBGYN Clinic, P.A. benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be paid. I understand that regardless of Insurance coverage , I am liable for all fees with deductible and cost shares being due on the date of service. I understand that in the case of default of payment of this account, I promise to pay any legal interest on the balance due, together with my collections costs and reasonable attorney's fees incurred to effect collection of this account.

SIGNATURE _____ WITNESS _____

DATE _____