

PATIENT INFORMATION

Patient Name: _____
LAST FIRST M.I. NICKNAME

Date of Birth: ____/____/____ Sex: _____ Pronouns: _____ Primary Language: _____

Marital Status: Single In a Relationship Married Widowed Divorced Social Security Number: _____ - _____ - _____

Patient Address: _____
STREET CITY, STATE ZIP CODE

Primary Phone: _____
CIRCLE ONE: HOME CELL WORK

Secondary Phone: _____
CIRCLE ONE: HOME CELL WORK

Email Address: _____

Employer: _____

Emergency Contact: _____
NAME PHONE RELATIONSHIP

How did you hear about us? Physician Friend/Family Yelp Google Insurance Other: _____

Who can we thank for this referral? _____

In order to bill your insurance(s) we must have a copy of your insurance card(s) presented at each visit.

INSURANCE INFORMATION			
Primary Insurance Information:			
Is patient subscriber?	Yes / No	If No: _____	
		Subscriber Name	Date of Birth Relationship
Insurance Company:	_____	ID number: _____	Group number: _____
Secondary Insurance Information:			
Is patient subscriber?	Yes / No	If No: _____	
		Subscriber Name	Date of Birth Relationship
Insurance Company:	_____	ID number: _____	Group number: _____

Insurance Disclaimer and Assignment of Benefits: I authorize payment of medical benefits to Seattle OBGYN Group and authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for all account balances. I acknowledge that all insurance information has been provided including primary and secondary insurance. Any insurance non-payment due to coordination of benefits will be my responsibility and subject to administrative fees as applies.

Signature: _____

Date: _____

