SEATTLE OB/GYN GROUP
1101 Madison Street, Suite 950
Seattle, WA 98104

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 □Returning Patient □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: _____