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: ________ Gender Identity: ______________ Primary Language: ______________

Marital Status: ☐Single ☐Dating ☐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

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: ______________________

For Future Use:

Initials: __________ Date: __________ Initials: __________ Date: __________

Initials: __________ Date: __________ Initials: __________ Date: __________