

South Metro Obstetrics & Gynecology

601 E. Hampden Ave Suite 370, Englewood, CO 80113 Ph 303.788.7888

10103 Ridgeway Pkwy Suite 223, Lone Tree, CO 80124

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Address: _____

Social Security Number: _____

City, State, Zip: _____

Marital Status: Married Single Divorced Widowed

Phone: _____ Home Cell Work

Who referred you?: _____

Phone: _____ Home Cell Work

Primary Physician: _____

Email Address: _____

PATIENT EMPLOYMENT Employed Retired Unemployed Other

SPOUSE / EMERGENCY CONTACT

Employer: _____

Name/Relationship: _____

Phone: _____

Phone Number: _____

GUARANTOR (Financially Responsible Party) Same as Patient

Name: _____

Phone Number: _____

Address: _____

Social Security #: _____

City, State, Zip: _____

Date of Birth: _____

PRIMARY INSURANCE PLAN & POLICY HOLDER: Same as Patient Same as Guarantor Other

Policy Holder (Insured): _____

Insurance Carrier: _____

Policy Holder Phone: _____

Policy Holder Social Security: _____

Policy Holder Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE PLAN & POLICY HOLDER: Same as Patient Same as Guarantor Other

Policy Holder (Insured): _____

Insurance Carrier: _____

Policy Holder Phone: _____

Policy Holder Social Security: _____

Policy Holder Date of Birth: _____

PATIENT RELEASE

Release: I hereby consent to the release of information provided to, or generated by OBGYN Affiliates, to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to OBGYN Affiliates. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances.

Verification: I hereby verify that all of the above information is true and correct as of the date signed below.

Patient Signature: _____ Date: _____