Lake Obstetrics and Gynecology, Inc.

PATIENT INFORMATION

PERSONAL INFO:

_____

Last Name First Name MI Nickname

_____ _____ _____

Date of Birth Social Security Number Maiden/Previous Name

_____

Street Address Apt./Bldg. City State Zip

_____ _____

Home Phone Number Cell Phone Number

_____ Marital Status: ☐ Married ☐ Single ☐ Divorced

Email Address ☐ Widowed ☐ Partner ☐ Separated

EMERGENCY CONTACT:

_____ _____

Emergency Contact Name Phone Number

_____ _____

Relationship to Patient If a Minor- Parent/Guardian Contact Name

EMPLOYER INFO:

_____ _____

Employer Name Occupation

_____

Employer Address City State Zip

_____ Work: ☐ Full Time ☐ Part Time

Work Phone

Student: ☐ Yes ☐ No If Yes: ☐ Full Time ☐ Part Time

PHARMACY INFO:

_____

Pharmacy Address (Street Name) City

RX Consent ☐ Yes ☐ No - Allow Healthcare Provider to obtain medication history from pharmacy, health plans, and other healthcare providers.

_____

Primary Care Doctor

(Continued on back)

ADDITIONAL PERSONAL INFO:

RACE	***ETHNICITY***	***LANGUAGE***
☐ American Indian	☐ Hispanic	☐ Chinese
☐ Asian	☐ Non-Hispanic	☐ English
☐ Black/ African American	☐ Chinese/ Mandarin	☐ Spanish
☐ Filipino	☐ Other_____	☐ Other_____
☐ Hispanic/ Latino/ Spanish		
☐ Italian		
☐ White/Caucasian		
☐ Other_____		

INSURANCE INFO:

	PRIMARY INSURANCE	***SECONDARY INSURANCE***
Insurance Name		
Policy Holder Name		

If you are NOT the Policy Holder, please provide the below.

Relationship to Patient		
Street Address		
City, State, Zip		
Date of Birth		
Social Security #		
Employer		

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY BILL.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE. WE URGE YOU, TO PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO ANY TESTING OR SURGERY BEING PERFORMED. FAILING TO COMPLY WITH THIS SUGGESTION COULD RESULT IN YOU, THE PATIENT, BEING RESPONSIBLE FOR ALL COST INCURRED. PLEASE REMEMBER, YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY AND **NOT WITH YOUR INSURANCE COMPANY AND YOUR DOCTOR.**

I IRREVOCABLY ASSIGN THE BENEFITS PAYABLE FOR COVERED SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO PROCESS THIS CLAIM. I, THE PATIENT ASSUME RESPONSIBILITY FOR ANY CO-PAYS, DEDUCTIBLES, NON-COVERED, OR UNPAID SERVICES. ADDITIONALLY, I UNDERSTAND THAT IF I AM IN DEFAULT IN PAYING MY BILL AND A COLLECTION AGENCY IS ENGAGED, I WILL BE REPONSIBLE FOR ANY FEES RESULTING FROM THIS ACTION.

_____

PATIENT/ RESPONSIBEL PARTY SIGNATURE DATE

OR

FOR PATIENTS WITH ***MEDICARE,*** PLEASE READ AND COMPLETE THE FOLLOWING: I CERTIFY THAT THE INFORMATION GIVEN BY ME APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTHCARE FINANCING ADMINSTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR COVERED MEDICARE SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT.

_____

PATIENT SIGNATURE DATE

(Continued on back)