4224 SWISS OBGYN, LLP

PATIENT REGISTRATION INFORMATION
(Please complete ALL sections)

PATIENT PERSONAL INFORMATION:

Name: _____
Last Name First Name Middle Initial

Date of Birth: ___/___/___ Social Security #: _____-_____-_____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Address: _____Apt #_____ City: _____

State: _____ Zip: _____ Email: _____

Race: _____ Ethnicity: _____ Language: _____

Marital Status: Single Married Divorced Widowed Sex: Female Male

Spouse: _____ Date of Birth: _____ SS# _____

PATIENT'S RESPONSIBLE PARTY INFORMATION:

Relationship to patient: __ Self __ Spouse __ Child __Other _____

Name: _____
Last Name First Name Middle Initial

Date of Birth: ____/____/_____ Social Security # _____/_____/_____

Home Phone (___)_____ Cell Phone (___)_____Work Phone: (___)_____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION: (Please present card to receptionist)

PRIMARY Insurance Name: _____

Address: _____ City: _____State: _____ Zip: _____

Name of Insured: _____ Date of Birth: ____/____/_____

Relationship to insured: ___Self ___ Spouse ___ Child ___ Other _____

Policy #: _____ Group #: _____ Copay: _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of Birth: ____/____/_____

Relationship to insured: ___Self ___ Spouse ___ Child ___ Other _____

Policy #: _____ Group #: _____ Copay: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

PATIENT REFERRAL INFORMATION:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

PHARMACY INFORMATION:

Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone (_____)_____ Fax: (____)_____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to DRS GUNBY, PAYNE, LITTRELL, & HARPER and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____