OBSTETRIX MEDICAL GROUP

PATIENT REGISTRATION FORM

Account # _____

GENERAL INFORMATION

PATIENT INFORMATION

How well do you speak English? ___ Very Well ___ Well ___ Not Well ___ Not at All

Name (First, M.I., Last): _____ DOB: _____/_____/_____

Mailing Address: _____ Apt # :_____ Cell #:_____

City, State, Zip Code: _____ Phone #:_____

SSN#: _____/_____/_____ Marital Status: (Please Circle) Single Married Divorced Widowed

Patient's Employer: _____ Work #: _____

SPOUSE/GUARDIAN INFORMATION

Name: _____ DOB: _____/_____/_____

SSN#: _____/_____/_____ Relationship to Patient _____

Employer: _____ Work #: _____

Nearest relative NOT at your address: _____

Street Address, City, State, Zip: _____

Phone #: _____ Relationship to patient _____

REFERRING PHYSICIAN INFORMATION

Dr.'s Name: (First)_____ (Last)_____Specialty: (i.e. OBGYN/PCP_____

Street Address, City, State, Zip: _____

Phone #: _____ Fax #: _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Company: _____ HMO__ PPO__ POS__ EPO__ OTHER __

Insurance Company Telephone Number: _____ Effective date:_____

Insured: _____ DOB: _____ Relationship to Patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: _____

Secondary Insurance Information

Name of Company: _____ HMO__ PPO__ POS__ EPO__ OTHER __

Insurance Company Telephone Number: _____ Effective date:_____

Insured: _____ DOB: _____ Relationship to patient: _____

Insured ID #: _____ Group #: _____

Insured Place of Employment: _____

Insured Business Telephone Number: _____

PATIENT RESPONSIBILITY

I authorize the release of any medical records or other information necessary to process my insurance claims on my behalf. I authorize Obstetrix Medical Group of Houston to appeal all insurance claims as appropriate on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services whether or not covered by insurance.

SIGNATURE:_____ Date_____