Obstetrix Medical Group of the Mountain States

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

How well do You Speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Patient's Name: (Last) _____ _____ (First) _____ (Middle) _____

Address: _____City, State, ZIP: _____

Phone: *Home* _____ *Cell* _____ *Work* _____ Email:_____

Date of Last Menstrual Period: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other _____

Social Security Number: _____-_____ -_____ Date of Birth: _____ /_____ /_____

Employment Status: ☐ Employed Full-Time / Part-Time ☐ Unemployed ☐ Student Full-Time / Part-Time ☐Retired

Employer: _____ Occupation _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: (Last) _____ (First) _____ (Middle) _____

Address: _____City, State, ZIP: _____

Social Security Number: _____-_____ -_____ Date of Birth: _____ /_____ /_____ ☐Female ☐Male

Phone: *Home* _____ *Cell* _____ *Work* _____ Email:_____

Employment Status: ☐ Employed Full-Time / Part-Time ☐ Unemployed ☐ Student Full-Time / Part-Time ☐Retired

Employer Name & Number: _____ Occupation _____

Patient Relationship to Responsible Party: _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk)

Name of Insured: _____Patient Relationship to Insured: _____

Insured Date of Birth: _____ /_____ /_____ Insured Social Security Number: _____

Insurance Company/Phone Number: _____ (_____)_____

Subscriber ID (Policy Number): _____ Group ID: _____ Co-pay Amount: _____

Effective Date: _____ ☐ Female ☐Male

Insurance Company Address: _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk)

Name of Insured: _____Patient Relationship to Insured: _____

Insured Date of Birth: _____ /_____ /_____ Insured Social Security Number: _____

Insurance Company/Phone Number: _____ (_____)_____

Subscriber ID (Policy Number): _____ Group ID: _____ Co-pay Amount: _____

Insurance Company Address: _____

(1) I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

(2) I authorize any holder of medical or other information about me to release this information to the Social Security Administration, Health Care Financing Administration, my insurance company, this physician's office, my attorney or other physician offices.

(3) I authorize direct payment of benefits to Obstetrix Medical Group of the Mountain States. I understand that I am financially responsible for all charges whether or not paid or covered by my insurance company.

(4) We participate in several insurance plans and will work with you and your insurance carrier. However, you must make sure that your plan obligations are met, including providing a current insurance card at each visit, paying the patient portion due at the time of service, using network providers for referrals and participating in the pre-certification process.

Patient (or Responsible Party) Signature _____ *Date* _____