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Best Choice Obstetrics & Gynecology

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Patient Information

Today's Date_____ How did you hear about us: __ Friend __Internet __Media __ Referral

Patient Name_____

Date of Birth _____Age_____ Marital status: Single, Married, Widowed, Divorced

Street Address_____ City_____

State_____ Zip Code _____

Occupation _____

Social Security #_____

Phone: Home (____) _____ Mobile (____) _____ Work (____) _____

E-Mail address: _____

Preferred Method of Contact: Mail Text/SMS Email Phone (circle one)

If married, spouse's name (if minor, parents' names) _____

Date of birth_____ Work phone _____ Employer _____

Occupation _____

Emergency contact name, relationship, & phone #

_____

Background: ___ Asian ___ American Indian/Alaskan Native ____ Black or African-American

___ Caucasian/White __Hawaiian Native ___ Mixed (more than one)

Other_____ ___ Do not wish to answer

I identify as: ___ Hispanic ___ Non-Hispanic

Insurance Information

Primary Insurance_____ PPO_____ HMO_____

Phone Number (____) _____ Subscriber name_____

Date of Birth_____ Subscriber Social Security # _____

Employer_____ Identification Number _____

Group Number_____

Secondary Insurance_____ PPO_____ HMO_____

Phone Number (____) _____ Subscriber name_____

Date of Birth_____ Subscriber Social Security # _____

Employer_____ Identification Number _____

Group Number_____

NO Insurance: Self Pay- Fee Options needed _____Yes _____No

Is this visit a worker's compensation claim? Yes No Contact person & phone #_____

Is this visit related to an accident? Yes No (if yes, please fill out an accident form)

Your insurance company has asked that any co-payment be paid at the time of service. If your insurance company requires referrals, we need your referral prior to being seen. By signing below, you hereby authorize Best Choice OB-GYN to file your insurance claim for the services received in the office and/or hospital from any physician in this group. You authorize us to send any medical information needed to process your claim. You also authorize payment on your behalf be made to Best Choice OB-GYN. Thank you.

Signature (if minor, parent's signature) _____
Date_____