PATIENT INFORMATION

Today's Date:

How did you hear about us: friends, internet, health insurance company, referral, other ____

Name:

Date of Birth:

Social Security Number:

Address:

Phone Numbers : Cell Phone:

House phone:

Work phone:

Email:

Emergency Contact

Name:

Phone number:

Relationship:

I am Asian, Native Indian, Native Alaskan, African American/Black, Caucasian/White, Native Hawaiian, Mixed/Other____

I identify as Hispanic, Non-hispanic.

HEALTH INSURNCE INFORMATION

Primary Health Insurance

Name of Health Insurance Company

Member ID:

Subscriber Name:

Date of Birth:

Social Security Number:

Group Number:

Employer:

Secondary Health Insurance

Name of Health Insurance Company:

Member ID:

Subscriber Name:

Date of Birth:

Social Security Number:

Group Number:

Employer:

Your Health 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 be 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 the Best Choice OB/Gyn. You authorize us to send any medical information needed to process the claims. You also authorize payment on your behalf be made to Best Choice OB/-GYN. Thank you.

Signature_____________________________ **Date**_________________________

(If minor, Parent/Guardian)