OBSTETRICAL AND GYNECOLOGICAL CARE

PATIENT INFORMATION

Date ________________ Referring Physician/Clinic/Other ______________________________

(Address) ______________________________

Social Security Number ______________________ Birth Date ______________ Age __________

Legal Name ______________________________ Preferred First Name ____________________

First Name MI Last Name

Address ______________________________ Home Phone ____________________

Cell Phone ____________________

City ____________________ State ____________________ Zip ____________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Maiden Name ____________________ Previous Names ____________________

Employer ______________________________ Position ____________________

Business Phone Number ____________________ OK to call you at work? ____________________

Husband's Name ____________________ Husband's Date of Birth ____________________

Husband's Employer ______________________________ Position ____________________

If a minor: Father's Name ______________ Phone Number __________ Employer __________

(or student) Mother's Name ______________ Phone Number __________ Employer __________

Address (if different) ______________________________

Emergency Contact

1. ____

Name Relationship to patient Phone Number

2. ____

Name Relationship to patient Phone Number

INSURANCE INFORMATION - Please fill out completely

Primary Insurance Carrier ______________________________ Effective Date ____________

Primary Cardholder ____________________ Relationship to patient __________ DOB __________

Policy Number ____________________ Primary Cardholder's SS# ____________________

Group Number ____________________ Group Name/Employer ____________________

Secondary Insurance Carrier ______________________________ Effective Date ____________

Secondary Cardholder ____________________ Relationship to patient __________ DOB __________

Policy Number ____________________ Secondary Cardholder's SS# ____________________

Group Number ____________________ Group Name/Employer ____________________

FINANCIAL POLICY (Please read and sign)

You should look upon your insurance policy realistically as a device which may reimburse you for medical services.

As a courtesy to you, we will complete the forms necessary pertaining to your claim and submit them to your insurance carrier. As we are not a party to the agreement between you and your insurance carrier, we are not responsible for how much and when they pay your claim. You are responsible, at the time of service, for payment of any deductible, co-payment, and any estimated balance not payable by your insurance company. The remainder of the bill is to be paid 45 days from the date services are provided.

If at the time of service, you do not present ALL insurance cards, we may not be able to bill them and the balance will be your responsibility. If you do not have any insurance coverage, we expect payment at the time of services. If this is not possible, we ask that you make financial arrangements prior to your appointment. The bill is to be paid in full within 45 days from the date services are provided.

I authorize my insurance company to make payment for medical expenses to my doctor for services performed.

I authorize release of medical information to my insurance company as required

______________________________________ ____________________

Signature (Patient and/or Guardian) Date

Over →

OBSTETRICAL & GYNECOLOGICAL CARE

EAU CLAIRE WOMEN'S CARE
OBSTETRICS-GYNECOLOGY CLINIC OF EAU CLAIRE

PATIENT ACKNOWLEDGEMENT OF PRIVACY NOTICE

By signing this form, you acknowledge that you may receive, upon request, a copy of the Privacy Notice for Obstetrical & Gynecological Care which explains how your health information will be handled in various situations. I understand that, by signing this form, I am confirming my written permission for disclosure of my protected health information as described in this form.
I agree to allow my health care information to be shared, when needed, between Eau Claire Women's Care, S.C. and OB-GYN Clinic of Eau Claire, S.C. without a separate signed release of information.

By checking this box, I verify:

☐ I am aware that I may request a copy of Obstetrical & Gynecological Care's Privacy Notice. If I have any concerns and/or questions about the privacy of my health information I will be given the opportunity to discuss them.

Please authorize release or discussion of your medical information by indicating below the name of people we may release or discuss medical information to. This authorization does not allow release of medical information to insurance companies, attorneys, etc.

I do/do not agree to allow the release of information or discuss aspects of my health care with my:
Spouse/Significant Other
(Name) ______________________________
Children:
(Names) ______________________________
Other:
(Names) ______________________ Relationship ______________

I, certify that the information on this form is true to the best of my knowledge and in effect until I choose to revoke it.

Patient Signature ______________________________ Date ____________

Guarantor Signature ______________________ Relationship ______________

OFFICE USE ONLY

Obstetrical & Gynecological Care staff should complete if Acknowledgement Form is not signed:
Does patient have a copy of the Privacy Notice: ☐ Yes ☐ No
Reason why the patient was unable to sign an acknowledgement form: ______________

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