

SOUTH CAROLINA OB~GYN ASSOCIATES, P.A.

PATIENT INFORMATION (Please Print)

(Form must be completely filled out and signed.)

DATE _____ SOCIAL SECURITY # _____

NAME _____ Single Married
DATE OF BIRTH _____ AGE _____ Widowed Divorced

STREET ADDRESS _____
(City, State, Zip Code) _____
HOME PHONE # _____ CELL PHONE # _____
Email Address: _____

EMPLOYER _____ WORK # _____
Occupation _____ City _____
Work Status: **(check one)** Full Time Part Time
Student: **(check one)** Full Time Part Time School _____

SPOUSE'S NAME _____
DATE OF BIRTH _____ SOCIAL SECURITY # _____

EMPLOYER _____ WORK# _____
Occupation _____ City _____

PRIMARY INSURANCE _____
Name of Insured _____
SS# of Insured _____ Group # _____

SECONDARY INSURANCE _____
Name of Insured _____
SS# of Insured _____ Group # _____

Would your religious preference prevent you from receiving emergent medical care, as in blood transfusions? Yes No

Name, Address, Telephone # and Relationship of person to be contacted in any medical emergency
(other than person listed above).

Referred by: _____

ASSIGNMENT OF INSURANCE BENEFITS & HIPAA:

(We must have your signature below in order to process your insurance claims.)

"I authorize release of information to insurance carriers and/or other health care providers as may be necessary to file a claim or facilitate my health care. I ASSIGN PAYMENT OF BENEFITS TO THE HEALTH CARE PROVIDER/GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. Patient-due balances are due and payable within 30 days of statement. Accounts sent to a collection agency will have related costs added to the owed amount. I have received or have been offered a copy of SC OB-GYN's "Notice of Privacy Practices." A copy of this signature is as valid as the original. "

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Patient's Signature