

North Florida Obstetrical & Gynecological Associates, PA

Confidential Patient Information Form

Form must be filled out completely to ensure correct claim processing.

Social Security _____ Patient _____
(Last) (First) (Middle Initial)

Date of Birth _____ Address _____
(Street #) (City) (State) (Zip)

Home Tel#: _____ Work Tel#: _____ Employer _____

Patient E-Mail _____ Marital Status _____ Employment Status _____ Student _____
(S M S D W Sep) (FT PT Ret N/A) (FT PT)

Referred by _____

Referring Physician _____ Primary Care Physician _____

Patient Cell # _____ Emergency Contact _____
(Name and Phone Number)

Spouse's name or other responsible party: _____ Phone # _____

Pharmacy Name, Phone #, Fax # and address _____

Primary Insurance: _____ Subscriber (Insured) Name _____

Subscriber: Date of Birth _____ Social Security # _____ Employer _____

ID# _____ Group Name & # _____ Patient Relationship to Insured _____
(Self, Spouse, Child)

Insurance Address _____
(City) (State) (Zip)

Second Insurance: _____ Subscriber (Insured) Name _____

Subscriber: Date of Birth _____ Social Security # _____ Employer _____

ID# _____ Group Name & # _____ Patient Relationship to Insured _____
(Self, Spouse, Child)

Insurance Address _____
(City) (State) (Zip)

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A. for their customary fee for the services rendered to me. I realized that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.) I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB/GYN harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Registered Nurse Practitioner (ARNP), Midwife (ARNP/CNM) or Physician Assistant (PA) and if I am scheduled with them, I am willing to see them instead of the doctor.

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on 6/23/2010. I acknowledge that I have read this authorization and fully understand its contents.

Signature _____ Date _____