

Account ID	Chart ID	Other ID
------------	----------	----------

Patient Information									
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #		
Address			Home:		How did you hear of us?				
Address 2			Work:						
			Cell:						
			Email:						
City	State	Zip Code	Employer Name & Address				Occupation		
Emergency Contact		Phone	Pharmacy			Pharmacy Phone			

Physician	Family Physician	Referring Physician
-----------	------------------	---------------------

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)									
1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #			
Address			Home:		Work:		Email:		
City	State	Zip Code	Employer Name & Address				Occupation		
2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #			
Address			Home:		Work:		Email:		
City	State	Zip Code	Employer Name & Address				Occupation		

HIPAA Approved Contacts									
1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #		Relationship		
Address		City	State	Zip Code	Home:	Cell:	Work:		
2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #		Relationship		
Address		City	State	Zip Code	Home:	Cell:	Work:		

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to OB/GYN Centre of Excellence , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	OB/GYN Centre of Excellence	
X		2341 McCallie Avenue, Parkridgepl	Phone: 423-629-9743
		Chattanooga, TN 37404	Email:

Please attach all pertinent insurance ID cards for photocopying.