Contemporary Obstetrics & Gynecology, PC

Patient Registration Form

(All bolded fields are required)

Legal Name_____

Preferred Name _____ **Date of Birth** _____ SSN_____

Address _____APT#_____ **City, State, Zip** _____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

Please circle which number(s) we may leave messages at: HOME CELL WORK

Employer _____ Occupation _____

Race: ☐African American ☐Indian/Alaska Native ☐Asian ☐Hispanic/Latino ☐Native Hawaiian ☐White ☐Other:_____

Marital Status: ☐Divorced ☐Separated ☐Single ☐Widowed ☐Married (list maiden name)_____

Spouse's name _____ Date of Birth _____

Phone # (____)_____ Circle: Cell# Home# Work#

**Do we have your permission to share information with this person if they were to call? Yes / No

Emergency Contact ☐Spouse (see above) OR ☐Other (see below)

Name _____ Phone # (____)_____

Relationship _____

**Do we have your permission to share information with this person if they were to call? Yes / No

Primary Care Physician Name _____ Phone # (_____)_____

Preferred Pharmacy _____ Location _____ Phone # (_____)_____

Who can we thank for referring you to our office? ☐Doctor_____ ☐Internet ☐Friend/Relative_____ ☐Other_____

Primary Insurance _____ **Policy Holder's DOB**_____

Policy Holder's Legal Name _____ SSN _____

Relationship to you: ☐Self ☐Spouse ☐Parent ☐Other_____

Secondary Insurance_____ Policy Holder's DOB_____

Policy Holder's Legal Name_____ SSN_____

Relationship to you: ☐Self ☐Spouse ☐Parent ☐Other_____

MUST HAVE BACK OF FORM COMPLETED AND SIGNED. Thank You.

Release of Information

I understand that as defined by the privacy regulations pronounced pursuant to the Health Insurance Portability Accountability Act of 1996 (HIPAA), the information obtained or created will be safeguarded. We may use and disclose your individually identifiable health information for purposes of treatment, payment and health care operations. However, your personal health information (PHI) and accounting details will not be released to anyone without your consent, except as allowed by law. Our detailed Privacy Policy is available upon request, or you may request a copy mailed to you by contacting our office at any time. By signing below I acknowledge that I was offered a printed detailed copy of HIPAA Notice of Privacy Practices.

Assignment of Insurance Benefits & Payment Policy

I hereby authorize payment directly to CONTEMPORARY OBSTETRICS & GYNECOLOGY, P.C. for the surgical and/or medical services as described. I understand that I am responsible for payment of my bills and that my insurance company will be billed for any payable benefits as a service to me.

I authorize the release of information regarding my condition, as necessary, to process these and/or related claims.

Co-pays are due at the time of service; we accept cash, VISA, MasterCard, Discover, and personal checks. A $10.00 billing fee is assessed every month in which a balance is carried over 60 days. Please contact the billing department at (248) 656-2022 with questions. There is a $35.00 fee for returned checks (NSF).

I acknowledge I am at least 18 years of age, have read, understood and agree to abide by the policies described above. Further, all information I have provided is accurate to the best of my knowledge. If I wish to revoke this authorization, it must be done in writing.

Signature _____ **Date** _____

Print Name_____

Relationship to patient (if not patient)_____