PATIENT INFORMATION SHEET

Moscow-Pullman OB-GYN

PATIENT NAME____ **SOCIAL SECURITY #**_______-______-_______

Age _______ **DATE OF BIRTH**____________________ Home phone (___) _______________

Address____City__________________ST________ZIP____________

Employer's Name_______________________________________ Occupation________________________________

Work/Message (___)___________________________ Cell phone/other (___) _____________________________

Primary Care Physician ____ Phone (___)_______________________

Spouse's name__________________________________Spouse's social security #_______-______-_______

Employer______________________________________Occupation____

BILLING ADDRESS (If different from above)

c/o Name____Relationship_____________________

Address____City______________ST_________ZIP____________

STUDENTS AND MINORS

Father's name____________________________________ Mother's name______________________________________

Father's address__________________________________ Mother's address___________________________________

City_______________________State_____ZIP_________ City_________________________State_____ZIP_________

Father's phone (____)_________________ Mother's phone (   )____________________

Father's employer_________________________________ Mother's employer__________________________________

Father's occupation_______________________________ Mother's occupation________________________________

Father's work phone (_____)___________________ Mother's work phone (_____)_____________________

EMERGENCY CONTACT

Name____Relationship_____________________

Address____City______________ST_________ZIP____________

Home phone (____)___________________________ Cell/other phone (___) ___________________________

INSURANCE INFORMATION

Primary insurance________________________________ Secondary insurance_________________________________

*****MOST OF YOUR LAB WORK WILL BE BILLED TO YOU BY OUTSIDE LABORATORIES*****

MEDICAL RELEASE: I authorize any holder of medical information about me to release to my insurance companies and their agents any information needed to determine benefits or the benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT: I, the undersigned, authorize payment of medical benefits to be made directly to Devlin & Huberty, P.S. I agree to pay my portion at the time services are rendered. I understand that my visit will be billed to my insurance if I have provided copies of my insurance cards. I understand and agree that (regardless of my insurance status) I am ultimately responsible for payment of any professional services rendered. I also understand a finance charge will be added to each charge on my account that has not been paid within 60 days. (No finance charge will be added to charges that are waiting payment from your insurance company.) The FINANCE CHARGE will be computed at the rate of 1.5% per month or an ANNUAL PERCENTAGE RATE of 18% with the exception of Medicare which, by law, cannot be assessed finance charges.

I have read and understand the above release and assignment of benefits.

PATIENT'S SIGNATURE ____Date___________________

(If patient is a minor, the parent or guardian must also sign below.)

PARENT/LEGAL GUARDIAN SIGNATURE____Date______________