PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. All information provided on this form is confidential. Please print.

Patient Name: Last ____________________ First ___________________M.I. ________
SSN ________ - _____- _____ Birth Date ___ ___ _____ Sex ___ CDL __________
Address ________________________ City ______________ State _______ Zip ________
Home Phone ( ) ____ - _____ Cell Phone ( ) ____ - _____ Marital Status _____
Patient's or Parent's employer _____________________ Work Phone ( ) ____ - ____
Work address ___________________ City ______________ State _______ Zip ________
Spouse or parent's name _______________________ Employer _____________________
Address ________________________ City ______________ State _______ Zip ________
Emergency contact ___________________________ Relationship ___________________
Emergency Contact's Phone ( ) ____ - _____ Office Referral ____________________

RESPONSIBLE PART

Name of Party: Last ____________________ First ___________________M.I. ________
Address ________________________ City ______________ State _______ Zip ________
Home Phone ( ) ____ - _____ Work Phone ( ) ____ - _____ CDL ____________
Birth Date ___ ___ _____ Employer ____

INSURANCE INFORMATION

Name of Insured: Last ________________________ First ____________________M.I. __
SSN ________ - _____- _____ Birth Date ___ ___ _____ Relationship _____________
Employer _________________________________ Employer's Phone ( ) ____ - _____
Employer address ______________________ City ______________ State ___ Zip _____
Insurance Company _____________________ ID# ______________ PPO ____ HMO ____
Insurance address ______________________ City ______________ State ____ Zip _____
Deductible amount _________ Deductible amount used __________ Co-pay ____________

Do you have any additional medical insurance? Yes ____ No ____ If yes, complete the following:

Name of Insured: Last ________________________ First ____________________M.I. __
SSN ________ - _____- ______Birth Date ___ ___ _____ Relationship _____________
Employer _________________________________ Employer's Phone ( ) ____ - _____
Employer address ______________________ City ______________ State ____ Zip _____
Insurance Company _____________________ ID# ______________ PPO ____ HMO ____
Insurance address ______________________ City ______________ State ____ Zip _____
Deductible amount _________ Deductible amount used __________ Co-pay ____________

Genesis OB-GYN Medical Group

PAYMENT OF SERVICES

I realize that contributions made by my insurance company may not represent the full payment for the services rendered. I will be responsible for any additional charges. If my insurance does not cover all or only covers a portion of this visit(s), I will be responsible to pay this office the remaining balance.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Genesis Ob-Gyn Medical Group of the medical benefits, if any for services rendered to my dependents or me. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I authorize release of any information concerning my (or my child's health car, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Date______________ **Signature Patient _________________________________**
Date______________ **Signature Parent/Guardian _________________________**

CONSENT FOR TREATMENT

I___________________________________ or __________________________________
(Patient) ***(Parent or Guardian)***
For__________________________________
(Patient)

Hereby voluntarily, give consent to Dr. Wanda Wilburn and nurse to provide examination, diagnostic and medical procedures as are deemed necessary or desirable in my case.

I am aware that the practice of medicine is not an exact science and I acknowledge that no assurances or guarantees have been given to me as to the result of such examination, diagnostic and medical procedures. This consent is valid until such time as revoked in writing by the undersigned.

I understand that responsibility for payment for medical services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½ % percent finance charge (18% annually) will be added to any balance over 60 days. In the case of default I (we) promise to pay legal interest on the indebtedness. Together with such collection costs and reasonable attorney's fees which may be required to effect collection of this note.

Consent must be signed by the parent, legal guardian or next of kin when patient is a minor or physically or mentally incompetent.

Date______________ **Signature Patient _________________________________**
Date______________ **Signature Parent/Guardian _________________________**
Date______________ **Signature Witness _________________________________**