Lincoln OB-GYN, P.C.

Patient Demographic Sheet

(Please Print) Date: ____________________

Name: ____
(Last) (First) (MI)

Maiden Name: ____________________ Age: ______ Birth Date: ____________

Address: ____
(Street) (City) (State) (Zip)

Home Phone: ____________________ Social Security #: ____________________

Cell Phone: ____________________ Marital Status: S M W D Sep

Occupation: ____________________ Employed By: ____________________

Business Address: ____________________ Business Phone: ____________________

Spouse's Name: ____________________ Employed By: ____________________

Business Address: ____________________ Business Phone: ____________________

Do you have any allergies: ____

Referred By: ____________________ Religion: ____________________

Person to Notify in case of Emergency (other than spouse)

Name: ____________________ Home Phone: ____________________

Business Phone: ____________________ Relationship: ____________________

Insurance Information

Primary Ins: ____________________ ID Number: ____________________

Policy Holder: ____________________ Group Number: ____________________

Date of Birth: ____________________ Relationship to Patient: Self Spouse Parent Other

Secondary Ins: ____________________ ID Number: ____________________

Policy Holder: ____________________ Group Number: ____________________

Date of Birth: ____________________ Relationship to Patient: Self Spouse Parent Other

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to Lincoln OB-GYN, P.C. for professional services rendered. I understand that I am financially responsible for all services rendered. I understand that if my insurance requires a referral I am responsible for obtaining that referral.

Signature: ____________________ **Date:** ____________________

I hereby authorize Lincoln OB-GYN, P.C. physicians and/or staff to leave information regarding my Protected Health Information or Billing Information on my answering machine or voice mail.

Signature: ____________________ **Date:** ____________________