Patient Information Sheet

Patient ID:___________ Date:__________

First Name:____________ Middle Initial:______ Last Name:_____________

SSN:__________________ DOB:______________ Language:______________

Address:_______________ Primary Phone:_________________________

City, State, Zip:____________________ Home #:_____________________________

Email:_____________________________ Cell #:_________________________________

Patients Employer:_________________ Work #:_________________________________

Emergency Contact:________________

Phone:___________________________ Referring Provider:_____________________

Relationship:______________________ Primary Care Provider:___________________

May Release Information to:____

Primary Insurance:___________________ Policy #:______________________

Insurance Address:___________________ Group #:______________________

City, State, Zip:_____________________

Policy Holder:_______________________ Relationship:__________________

Policy Holder DOB:___________________

Secondary Insurance:_________________ Policy #:______________________

Insurance Address:___________________ Group #:______________________

City, State, Zip:_____________________

Policy Holder:_______________________

Policy Holder DOB:___________________ Relationship:____________________

Responsible Party:___________________ SSN:_______________________ Relationship:___________________

Address:____________________________ City, State, Zip:_________________________________

By providing my signature below I am acknowledging the following authorizations:

CONSENT TO TREAT – I authorize my physician and/or his/her designee to provide medical and diagnostic services he/she deems necessary and appropriate. I understand I have the right to ask questions and receive answers regarding my treatment plan. I also have the right to refuse treatment and see a second opinion.

ASSIGNMENT OF BENEFITS – I authorize assignment of all insurance benefits to Lincoln OB GYN, P.C. I authorize release of medical records to my medical insurance carrier, any information needed for processing this or related claims.
By providing my signature below I acknowledge the information provided is correct to the best of my knowledge.
I understand that I am financially responsible for all charges not paid by any insurance company.

____ ____________________

Signature of Patient or Parent/Legal Guardian of Minor Date