OB-GYN ASSOCIATES OF OAK RIDGE, P.C.
PATIENT INFORMATION SHEET
PAYMENT IS DUE WHEN SERVICES ARE RENDERED(*INCLUDES CO-PAYS AND CO-INSURANCE)

PATIENT'S NAME- LAST	FIRST	MIDDLE	MAIDEN	MARITAL STATUS S	M	W	D	SEP

AGE	BIRTHDATE	SOCIAL SECURITY #	LANGUAGE

ETHNICITY	HOME PHONE	CELL PHONE

STREET ADDRESS	CITY	STATE	ZIP

POST OFFICE BOX	CITY	STATE	ZIP	EMAIL ADDRESS

PATIENTS EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE #

EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP

SPOUSE OR PARENT'S NAME	BIRTHDATE	SOCIAL SECURITY #	PHONE #

SPOUSE OR PARENT'S ADDRESS	CITY	STATE	ZIP

SPOUSE OR PARENTS EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE #

EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP

FAMILY PHYSICIAN	PHONE #	FAMILY PHYSICIAN'S ADDRESS

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME		INSURANCE NAME	
SUBSCRIBER NUMBER		SUBSCRIBER NUMBER	
GROUP NUMBER	EFFECTIVE DATES	GROUP NUMBER	EFFECTIVE DATES
SUBSCRIBER'S NAME	Employer	SUBSCRIBER'S NAME	
SUBSCRIBER'S DOB	SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S SSN
PATIENT'S RELATIONSHIP TO THE SUBSCRIBER		PATIENT'S RELATIONSHIP TO THE SUBSCRIBER	

All Professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite Insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. Payment is due for services when rendered unless other arrangements have been made in advance. I consent OBGYN and any other owner or servicer of my account contacting me about my account, including using any contact information or cell phone numbers I provide, and I consent to the use of any automatic telephone dialing system and/ or artificial or prerecorded voice when contacting me, even if I am charged for the call under my phone plan.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE OB-GYN ASSOCIATES OF OAK RIDGE, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature: _____ Date: _____