Account #: _____

Date: _____

Fort Sanders Obstetrical & Gynecological Group, P.C. ®

Patient Information

☐ No Changes to Patient Information

Last Name,	First Name	Middle Name
Street Address	P.O. Box/ Apartment #	City
State	Zip Code	Date of Birth
( )	( )	( )
Home Phone	Mobile Phone	Work Phone
Former Name	Social Security #	Marital Status
Occupation	Employer	Email Address
Referred By	Primary Care Physician	Primary Care Physician Phone #

Insurance Information

☐ No Changes to Insurance Information

Primary Policy Holder's Name	Date of Birth	Social Security #	Relationship to Patient
Secondary Policy Holder's Name	Date of Birth	Social Security #	Relationship to Patient

Emergency Contact

		( )	( )
Name	**Relationship to Patient**	Home Phone	Mobile Phone

Please See Other Side

Fort Sanders Obstetrical & Gynecological Group, P.C. ®

Privacy Health Information Consent

HIPAA Privacy allows you the right to restrict use and disclosure of your Personal Health Information. You are allowed the right to request confidential communication using alternative means such as correspondence. Please allow us at FSOBGYN to protect your rights to privacy by filling out and consenting to your personal restrictions in communications.

I, _____(Patient Name) give permission to disclose my health information and account information to all listed parties below (spouse, children, and/ or other family members).

_____ _____

_____ _____

_____ _____

_____ _____

May we leave a message with detailed information? HOME: Y N WORK: Y N CELL: Y N

May we leave a message with call back number only? HOME: Y N WORK: Y N CELL: Y N

Other?_____

Written Communications/ Mailings? (Excludes Certified Letters) HOME: Y N WORK: Y N

Authorization and Release

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS, MEDICAL RECORDS, TREATMENT AND/OR CARE RENDERED TO ME OR MY CHILD DURING THE PERIOD OF CARE GIVEN BY FSOBGYN GROUP TO THIRD PARTY PAYORS AND/OR PRACTITIONERS . I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO FORT SANDERS OBGYN GROUP PC. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF AND DEPENDENTS.

I AM AWARE THAT PATHOLOGY AND LABORATORY SERVICES FOR EVALUATION AND DIAGNOSIS ARE NOT BILLED THROUGH FSOBGYN AND MAY REQUIRE OTHER PARTIES TO BILL ME.

_____ _____

Patient's Signature Date