Saint Joseph OB/GYN Associates

First Name ________________________MI_______Last Name______________________

Address:____

Home Phone ___________________ Work_________________Cell________________

DOB_________________SSN_________________ Male______ Female_______

Place of Employment______________________ Phone __________________________

Responsible Party if patient is under 18 years of age

Name_____________________________________ Phone________________________

Insurance Information

If you are not the policy holder please provide information below:

Policy Holder Name_______________________________ DOB___________________

Social Security Number______________________________________

Information regarding designated contact person:

Do you wish to designate a family member or friend with whom we may communicate regarding your appointments, test results and medical condition? If so you MUST supply name and phone number

Name_____________________________________ Phone________________________

Emergency contact not living with patient

Name___________________________________Relationship______________________

Address____Phone_________________

Payment is expected at time of service. I hereby authorize St. Joseph Medical Foundation, INC – DBA St. Joseph OB/GYN Associates to release my information aquired during the course of my examination and treatment needed to determine payment benefits or the benefits payable for related services to my insurance company and its agents and any other third party carrier as necessary to secure payment of benefits due. I hereby assign payment for services rendered directly to Saint Joseph Medical Foundation DBA St. Joseph OB/GYN Associates. I understand I am responsible for all charges regardless of insurance status. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

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Signature Date