OBSTETRICS & GYNECOLOGY ASSOCIATES
PATIENT INFORMATION FORM

Patient's Name_____ Age _____ Birthdate_____

Residence
Address _____ City_____ State _____ Zip_____

Mailing Address_____ Phone No._____
(AREA CODE)

Email Address_____

Social Security # _____ Driver's License #_____

DOCTOR: C.M.A. Rogers, IV.M.D. Helen Rogers, M.D. Ted N. Catranis, M.D. Amy McCoy, M.D.
(Please circle)

Marital Status (Please circle) Married Single Divorced Widowed

Patient Employed At_____ Work#_____

Husband's Name _____ Birthdate_____

Husband Employed At _____ Work Phone #_____

Address_____

If Patient is a minor, responsible party_____

Address_____

Home Phone #_____ Work Phone #_____

How do you intend to pay? _____Cash _____Check _____Credit Card Do you have insurance? ☐ Yes ☐ No

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Person financially responsible for this account_____

Nearest relative not residing with you_____

Relationship to Patient _____ Phone #_____

In case of an emergency, please contact_____

Phone #_____

Whom may we thank for referring you? _____ Relationship_____

Address_____ Phone #_____

OBSTETRICS & GYNECOLOGY ASSOCIATES

STATEMENT OF FINANCIAL POLICY

1 FORMS OF PAYMENT - We accept cash, check, MASTERCARD and VISA on your initial visit to our clinic. All fees for which you are responsible should be paid at the time of service, unless prior arrangements have been made. This will include all co-pays, deductibles, and non-covered amounts.

2 FILING INSURANCE -We routinely file insurance claims for you if your carrier is one with whom we are contracted (Medicare, Blue Cross/Blue Shield, CHAMPUS, some HMO's and PPO's).

3. SURGERY / OBSTETRICAL CHARGES - Our bookkeeper can help with arrangements if you have extenuating circumstances. Otherwise, it is our routine to collect the patient's portion of surgery and delivery charges prior to the anticipated date. Details of OB charges are explained in a separate pamphlet.

CONSENT FOR TREATMENT

Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgement of the physician(s) in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in the hospital or office. If a Pap smear or biopsy is deemed necessary, I hereby authorize Obstetrics & Gynecology Associates to send a specimen to a suitable outside laboratory for a pathology report.

SIGNATURE_____ DATE_____

WITHNESS_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Obstetrics & Gynecology Associates to release any medical information necessary to process health insurance claims.

LEGAL SIGNATURE_____ DATE_____