Referred By:_____

PATIENT INFORMATION

Age:	Date of Birth:	SS#:
Legal Name:		
How do you wish to be addressed (nickname)?:		
Address:		City, State, Zip:
Home:	Work:	Cell:
Email Address:		
Employer:		Position:
Address:		City, State, Zip:
❑ Single	❑ Married	❑ Widowed ❑ Divorced
Pharmacy Name and Number: Please remember to notify the office if your pharmacy changes.		

PLEASE FILL IN SPOUSE INFORMATION. IF THE PATIENT IS UNDER 18 FILL IN PARENT INFORMATION.

Name:		
Age:	Date of Birth:	SS#:
Employer:		Position:
Address:		City, State, Zip:
Home #:	Work #:	Cell #:

PRIMARY INSURANCE COMPANY

Name of Insurance Company:	Phone #:
Policyholder:	Relation to Patient:
Policyholder's Address:	City, State, Zip:
Policyholder's Date of Birth:	SS#:
Member ID #:	Group #:
Claims Address:	City, State, Zip:

We file secondary insurance for OBs and surgery patients only.

EMERGENCY CONTACT

Name:		Relation to Patient:
Home #:	Work #:	Cell #:

ALLERGIES

List ALL drug allergies:

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plan, to Vernon & Waldrep OB-Gyn Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance and I choose to see my physician at Vernon & Waldrep OB-Gyn Associates whether she is in-network or out-of-network, and this may or may not effect reimbursement by my insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

Patient's Signature:_____ Date:_____