OBGYN Group of Eastern Connecticut, P.C.

PATIENT INFORMATION FORM

(Please print legibly and complete all sections)

PATIENT INFORMATION

Last Name	First Name	Former /Maiden Name	MI	Date of Birth: / /
Street Address:	City:	State:	Zip:	Home Phone: ( )
Social Security Number: _ _	Driver's License Number:	State Issued:	Marital Status: ☐ S ☐ M ☐ D ☐ W	Cellular Phone: ( )
Preferred Language:	Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other _____			
Occupation:	Employer:			Work Phone: ( )
In case of Emergency Notify:				Phone Number: ( )
Name and Address of Nearest Friend/Relative Not Living With You:				Phone Number: ( )
Primary Care Physician and Address:				Phone Number: ( )

GUARANTOR INFORMATION (*Person financially responsible)*

Last Name:	First Name:	MI:		Home Phone: ( )
Street Address:	City:	State:	Zip:	Cellular Phone: ( )
Social Security Number: _ _	Sex: ☐ Male ☐ Female	Date of Birth: / /		Work Phone: ( )

INSURANCE INFORMATION (*Please provide your insurance card(s) so that we may retain a copy for our records)*

Primary Insurance Company Name:	Name of Policyholder (if different from the patient):	Patient Relationship to Policyholder:
Policyholder's Address (if different from the patient):	Policyholder's Phone Number:	Policyholder's Date of Birth:
Secondary Insurance Company Name:	Name of Policyholder (if different from the patient):	Patient Relationship to Policyholder:
Policyholder's Address (if different from the patient):	Policyholder 's Phone Number:	Policyholder's Date of Birth:

Referred By: ☐ Patient/Friend/Relative ☐ Insurance ☐ Website ☐ Physician _____

INSURANCE, ASSIGNMENT OF BENEFITS, PAYMENT AND NOTICE OF PRIVACY PRACTICES

I authorize OBGYN Group of Eastern Connecticut P.C. ("OBGYN Group") to apply for benefits on my behalf, or on behalf of my dependent who is the patient named above, for medical services rendered to me or my dependent and I request that all payments of such authorized insurance, Medicaid and/or Medicare benefits be directly to OBGYN Group. I authorize OBGYN Group to release to the Centers for Medicare and Medicaid Services (CMS) and its agents and/or my insurance company any information needed to determine benefits payable including HIV/AIDS, substance abuse and/or mental health information for related services. I certify that I or my dependent have active and valid insurance coverage and that I have supplied OBGYN Group with the most current and correct insurance information, identification card and information regarding the financial guarantor. I understand and agree that if I have failed to provide accurate information in a timely manner or if I am (or my dependent is) not eligible for such insurance benefits, claims submitted by OBGYN Group may be denied and I am financially responsible for and will make payment to OBGYN Group for any and all services not paid for by my health insurance. I understand that, by supplying my home or mobile phone number or email address, I am permitting my healthcare provider to use my contact information, the name of my care provider, the time and place of my scheduled appointment(s) and other limited information for the purpose of notifying me (directly or through an automated outreach and messaging system of a business associate) of an upcoming appointment, missed appointment, overdue wellness exam or other limited matters related to my healthcare as permitted under HIPAA. I understand that such messages may be left on my voice mail, answering system or with another individual who answers the call if I am unavailable at the number provided by me. I have been provided an opportunity to review the OBGYN Group Notice of Privacy Practices.

X_____ _____

Signature of Beneficiary/Guarantor Date