PATIENT INFORMATION

PATIENT

ACCT# _____

MRS./MS./MISS LAST _____ FIRST _____ MI _____

HOME #: ( ) _____ CELL # : ( ) _____ WK #: ( ) _____

SEX - F / M SS# _____ DOB _____ AGE _____ LICENSE# _____

MAILING ADDRESS: STREET _____ CITY _____ ZIP _____

HOME ADDRESS: STREET _____ CITY _____ ZIP _____

EMPLOYER: _____ ADDRESS: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ CELL / WK # _____

SEX - F / M SS# _____ DOB _____ AGE _____ LICENSE# _____

EMERGENCY CONTACT: (LOCAL RELATIVE OR FRIEND)

NAME: _____ ADDRESS _____ PHONE#: _____

REFERRED BY: _____ **YOU PRIMARY DOCTOR IS:** _____

RESPONSIBLE PARTY: (WHO'S INSURANCE IS IT?)

MR./MS./MISS/. LAST _____ FIRST _____ MI _____

SEX - F / M SS# _____ DOB _____ AGE _____ LICENSE# _____

MAILING ADDRESS: STREET _____ CITY _____ ZIP _____

EMPLOYER: _____ ADDRESS: _____ WK# _____

INSURANCE:

PRIMARY: NAME: _____ POLICY # _____ SUBSCRIBER: _____

INSURANCE ADDRESS: _____

SECONDARY: NAME: _____ POLICY # _____ SUBSCRIBER: _____

INSURANCE ADDRESS: _____

MEDICARE#: MEDICAID #:

PLEASE READ & SIGN THE FOLLOWING:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

I directly assign all medical/surgical benefits to **SUNWEST GYN. ASSOCIATES** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I further agree that a photocopy of this agreement shall be valid as the original. **I further understand that there is a $25.00 fee if I fail to notify the office of a cancellation 24 hours prior to my appointment.**

SIGN HERE: _____ DATE: _____