Premier Perinatal

Personal Information

Patient Name (Last): _____ (First):_____(Middle)_____
Address: _____ City/State: _____Zip: _____
Home Phone: _____ Cell:_____ Email:_____
Date of birth:_____Age:_____Social Security #:_____
Marital Status: S M D W Partner Name: _____Partner phone:_____
Emergency Contact (not partner): _____ Relationship: _____Phone: _____
Referring Physician: _____ Phone: _____
How did you hear about us? Physician _____ Patient: _____
Advertisement:_____Insurance Company:_____

Insurance Information

Primary Insurance Co. Information (name, address and phone # of person responsible for payment)
Subscriber: _____ Date of Birth: _____
Social Security #: _____ Relationship to Patient: _____
Address: _____ Phone: _____
Employer: _____
Address: _____ Phone: _____
Insurance Co. Name: _____Phone: _____
Address: _____ City/State: _____Zip: _____
Policy/ID #: _____ Group #: _____ Plan Name: _____

Secondary Insurance Co. Information (name, address and phone # of person responsible for payment)
Subscriber: _____ Date of Birth: _____
Social Security #: _____ Relationship to Patient: _____
Address: _____ Phone: _____
Employer: _____
Address: _____ Phone: _____
Insurance Co. Name: _____Phone: _____
Address: _____ City/State: _____Zip: _____
Policy/ID #: _____ Group #: _____ Plan Name: _____

RELEASE OF INFORMATION
I authorize the release of all information necessary to process my insurance claims and pertinent to my medical care. The release will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

Patient signature:_____ **Date:**_____

ASSIGNMENT OF BENEFITS
I assign all medical and/or surgical benefits including major medical benefits to which I am entitles, including Medicare, Blue Shield, HMO plans and commercial insurance to Premier Perinatal. This assignment will remain in effect until revoked by me in writing. I hereby authorize the above to release information to secure payment on my behalf.

Patient signature:_____ **Date:**_____

I understand that I am financially responsible for all charges. I have read this information and understand it.

Patient signature:_____ **Date:**_____