Patient Information:

Partridge Creek Obstetrics & Gynecology

LAST Name | FIRST Name | MI | Date of Birth / / | Age

- - | | | | |

SSN | Marital Status | Pharmacy | Location | Phone No.

Address | City | State | Zip

( ) | ( ) | ( )

Home Phone | Cell Phone | Work Phone

Indicate your primary method of contact: Cell Home Text Msg Email Work (circle one)

Email Address | Employer | ( ) Phone | Occupation

Primary Insurance Name:

Policy holder Full Name | Policy holder Employer | Policy holder D.O.B. | Relationship to patient

Secondary Insurance Name:

You will be asked to provide copies of all insurance cards, effective dates and policy holder information

Emergency Contact Person | ( ) Phone | Relationship

Who referred you to our office | Primary Care Physician

Authorization:

I authorize payment of insurance benefits to Partridge Creek Obstetrics & Gynecology. I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatment, including those that are applied to deductible, co-pay or non-covered/unpaid services. Accounts not paid within 30 days of the invoice date are subject to a **1.5%** monthly finance charge. Failure to pay for services rendered, your account may be turned over to a collection agency.

Release of Information:

I authorize Partridge Creek Obstetrics & Gynecology to release any and all medical information to my health insurance company necessary to process and pay any claim/claims.

Consent for Treatment:

I voluntarily consent to receive all such medical treatment that my medical provider considers beneficial to me. I understand that this care may include diagnostic tests, examinations, medical or surgical treatment. I am aware that the practice of Medicine is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the results or treatment and exams provided.

Consent to Testing:

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissues and products including Human Immunodeficiency Virus (HIV, the virus that causes AIDS) as deemed appropriate by the provider and I consent to this.

You have the right to an Advanced Directive (Durable Power of Attorney for Health Care). Please check if you have the following:
[ ] Durable Power of Attorney for Health Care [ ] I don't have either, but would like more information [ ] I don't need that information

Signature of Patient or Legal Guardian **Date** **Witness Signature** **Date**

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