Partriage Creek
Obstetrics Gynecology

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 Phone Occupation  Primary Insurance Name:  Policy holder Employer Phone Occupation  Primary Insurance Name:  You will be asked to provide copies of all insurance cards, effective dates and policy holder information  (					
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Address City State Zip    Mome Phone	LAST Name	FIRST Name	MI	Date of Birth	Age
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Home Phone Cell Phone 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:  Lauthorize payment of insurance benefits to Partridge Creek Obstetrics & Gynecology. Lagree 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:  Lauthorize 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:  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.	55.N	Marital Status	Pharmacy	Location	Phone No.
Home Phone Cell 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 Phone 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.	Address	City	State		Zip
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.		( )			•
Indicate your primary method of contact:    Cell   Home   Text Msg   Email   Work   (circle one)	Home Phone	Cell Phone		Work Phone	
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  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: Vountarily 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.	Indicate your primary method of contact:	Cell Home Text Msg Email	Work		
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**Patient Information:**