SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Information **Account #** _____

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Social Security Number _____ Drivers License _____
e-mail _____ Marital Status _____
Religion _____ Primary Language _____

Race: ___ African American/Black ___ Asian ___ Native Hawaiian/ Pacific Islander ___ Declined
___ American Indian/ Alaskan Native ___ Caucasian/White ___ Other Race ___ Unknown

Ethnicity: ___ Declined ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Unknown

Employer/School _____ Occupation _____

Emergency Contact Name / Relationship _____
Emergency Contact Number: _____ Cell: _____

Primary Care Physician _____ Referring Physician _____
Preferred Pharmacy _____ Location _____

Name of Insurance: (list in order of relevance)
Primary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____
Secondary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____
Tertiary Insurance Co: _____ Policy # _____
Name of Insured _____ Date of Birth _____

Responsible Party's Name _____ Date of Birth _____
Responsible Party's Phone _____ Employer _____
Responsible Party's Social Security Number _____

If you are currently covered under your parents insurance:
Can we contact your parents regarding insurance or billing information? ___ Yes ___ No

I hereby authorize and consent to all examination and treatment necessary for the care of the patient named below. I consent to any and all procedures incident to such treatment which are deemed necessary by the physicians. I authorize the release of medical information to process my claims and authorize Spartanburg & Pelham OB-GYN, P.A. direct receipt of insurance payment for services rendered. I hereby agree to pay Spartanburg & Pelham, OB-GYN, P.A. for all charges not covered by my insurance. I further acknowledge that I have been provided with a copy and given the opportunity to review the Notice of Privacy Practices of Spartanburg & Pelham OB-GYN, P.A. pursuant to the Federal regulations known as HIPPA privacy.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Relationship to Patient