Southern Indiana OBGYN

Patient Registration

Date: _____

Patient: _____
Last Name First Name Middle Initial Maiden Name

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Age _____ Birthdate _____

Social Security # _____ Marital Status: S M W D Spouses name _____

Patient's Employer _____

Position Held _____ Business Phone _____

Cell-phone: _____ Email: _____

Please complete this section with the insurance policy holder information ore if the responsible party is someone other than the patient

Responsible Party's Relationship to patient: _____

Name _____
Last Name First Name Middle Initial

Address _____

Home Phone _____ Birthdate _____ Social Security # _____

Other Information

Emergency Contact (outside of your home) _____ Phone # : _____

Primary Language Spoken: _____ Ethnicity: _____ Race: _____

Who referred you to Southern Indiana OBGYN: _____

Authorization and Acknowledgement

I authorize the physicians and Southern Indiana OBGYN staff to treat me, or my dependent. I also authorize the release of information to any physician or insurance carriers concerning the illness or medical treatment of myself, or my dependent, including but not limited to pregnancy, HIV, sexually transmitted diseases, and mental illness. I hereby assign to the providers all insurance payments for medical services rendered to myself or my dependent (except for those services for which I have paid for prior to the filing of the insurance claim on my behalf). I understand that I am financially responsible for services rendered and for charges not covered or timely paid by my insurance carrier(s)

_____ Date _____
Patient signature (Parent or Legal Guardian if patient is a minor)