

MEDINA OB/GYN ASSOCIATES, INC.

DATE _____

NAME:			
(LAST)	(FIRST)	(MIDDLE INITIAL)	(MAIDEN NAME)
ADDRESS:			
(STREET ADDRESS)	(CITY)	(STATE)	(ZIP CODE)
DOB: / /	SS#: - -	DRIVER'S LICENSE#:	
MARITAL STATUS:	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED
PATIENT INFORMATION:		PRIMARY INSURED'S INFORMATION:	
HOME TELEPHONE #		POLICY HOLDER:	
WORK TELEPHONE #		DATE OF BIRTH:	
CELL TELEPHONE #:		SOCIAL SECURITY #:	
E-MAIL ADDRESS:		INSURANCE NAME:	
EMPLOYER:		ADDRESS:	
OCCUPATION:		CITY/STATE/ZIP:	
EMPLOYER'S ADDRESS:		TELEPHONE #:	
CITY, STATE, ZIP		EMPLOYER:	
RELIGIOUS DENOMINATION:		ID NUMBER:	
		GROUP NAME & #:	
		CO-PAY AMOUNT:	

SECONDARY INSURANCE INFORMATION:	
INSURANCE NAME:	
ADDRESS	
CITY	STATE ZIP
TELEPHONE #	
POLICY HOLDER	DOB:
PLAN NAME:	
GROUP NAME:	GROUP #:
EMPLOYER:	

SPOUSE'S NAME:
SPOUSE'S OCCUPATION:
SPOUSE'S EMPLOYER:
REFERRED BY:
PRIMARY CARE PHYSICIAN:
NAME AND TELEPHONE NUMBER OF PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF AN EMERGENCY:

RELEASE OF INFORMATION.

I HEREBY AUTHORIZE THE MEDINA OB/GYN ASSOCIATES, INC. TO DISCLOSE ALL OR ANY PART OF MY MEDICAL INFORMATION TO:

1. ANY PERSON OR ENTITY THAT MAY BE LIABLE TO MEDINA OB/GYN ASSOCIATES, INC., FOR ALL OR PART OF THE CHARGES FOR MY MEDICAL CARE, INCLUDING, BUT NOT LIMITED TO;
2. HOSPITAL OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES AND PAYERS, WORKERS' COMPENSATION CARRIERS, AND WELFARE FUNDS;
3. ANY PERSON OR ENTITY THAT IS INVOLVED IN MY MEDICAL TREATMENT;
4. MY EMPLOYER;
5. ANY PERSON OR ENTITY THAT IS NECESSARY TO PROCESS A CLAIM FOR PAYMENT SUCH AS A BILLING COMPANY;
6. THE LEGAL COUNSEL OF MEDINA OB/GYN ASSOCIATES, INC. IN ANY MATTER TO WHICH SUCH INFORMATION IS RELEVANT AND NECESSARY;
7. COLLECTION AGENCIES EMPLOYED OR RETAINED BY MEDINA OB/GYN ASSOCIATES, INC. TO OBTAIN PAYMENT OF MY ACCOUNT; AND
8. PERSONS, COMMITTEES, OR ENTITIES PERFORMING AUDITS OR ANALYZING PATIENT MEDICAL INFORMATION FOR QUALITY OF CARE, PEER REVIEW, FINANCIAL OR COMPLIANCE PURPOSES.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

DATE