

OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C.

DATE _____
LAST NAME _____ FIRST NAME _____ INIT _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE (_____) _____ WORK PHONE (_____) _____ EXT _____
ALTERNATE CONTACT NUMBER (_____) _____
BIRTH DATE _____ AGE _____ SOCIAL SECURITY _____
MARITAL STATUS: SINGLE _____ MARRIED _____

EMPLOYER _____
ADDRESS _____

PARENT/SPOUSE NAME _____ BIRTH DATE _____
ADDRESS _____ PHONE _____
EMPLOYER _____
SOCIAL SECURITY _____ WORK PHONE _____

NEAREST RELATIVE _____
ADDRESS _____ PHONE _____

PRIMARY INSURANCE _____ ID# _____ ACC# _____
CARDHOLDER NAME _____ DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____ SOCIAL SECURITY _____

SECONDARY INSURANCE _____ ID# _____ ACC# _____
CARDHOLDER NAME _____ DATE OF BIRTH _____
EMPLOYER _____
ADDRESS _____ SOCIAL SECURITY _____

REFERRED BY _____
ADDRESS _____ PHONE _____

I authorize OBGYN Associates of Northern Indiana to release information concerning illness or treatments to my insurance carrier and also direct payment to the physician(s) who rendered medical services. I will accept responsibility for payment of fees submitted by OBGYN Associates of Northern Indiana for any balance not covered by my insurance.

PATIENT SIGNATURE _____ DATE _____

As parent/guardian, I give my permission to consult with and/or treat _____
_____. I also authorize OBGYN Associates of Northern Indiana to submit fees for services rendered to my insurance carrier for payment. If, for any reason, the fees are not covered I agree to accept responsibility for the outstanding balance.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Based on the commitment we have made to our patients, the profession and ourselves, we will not accept as patients those who refuse to accept blood or blood products. This decision is based on the possibility of an emergency situation occurring whereby the patient needs a life-saving transfusion. In this case permission would first be obtained from the patient or their family if the patient is unable to make that decision. In the case of a planned and scheduled surgery, a patient may donate their own blood prior to surgery or have a family member donate in their behalf.

I fully accept and understand the above statement. _____ (Initial)