Patient Demographic Form (Please PRINT Patient)

Name:_____Nickname/AKA:_____

Date of Birth:_____ Social Security Number_____Sex:_____

Home Address:_____

City: _____ State: _____ Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____

Preferred method of contact: (circle one) Phone Email Letter

Marital Status: Married☐ Single ☐ Divorced ☐ Separated☐ Widowed☐

Language (other than English):_____ Race:_____ Ethinicity:_____

Email address: _____ Employer: _____

Spouse/Parent: _____ Phone #:_____

Emergency Contact: _____ Phone #: _____

How did you hear about us: _____

INSURANCE INFORMATION

Ins Co Name: _____ Policy/ Member ID #:_____

Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Policy Holder: _____ Sex: _____

Address: _____City: _____ Zip Code: _____

Home #:_____ Date of Birth: _____

Employer: _____

SECONDARY INSURANCE

Ins Co Name: _____ Policy/ Member ID #:_____

Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Policy Holder: _____ Sex: _____

Address: _____ City: _____ Zip Code: _____

Home #: _____ Date of Birth: _____

Employer: _____

Diagnostic Testing: We recommend that you call your insurance company to be informed of your benefits for any diagnostic test that After Ours OBGYN may order for you. These tests include mammograms, DEXA scans, labs, CT's, etc… You should inquire if pre-certification is needed. If so, you will need to contact our office one week prior to your scheduled procedure to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our registrar to be copied. If we are unable to verify your insurance, you will be responsible for payment at the time of service. After Ours OBGYN participates with Medicare and most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract. ϖ All co-payments, deductibles, and co-insurance as applicable are due at the time of service. ϖ Payment in full is due at the time of treatment for all private pay patients, Medicare patients for non-assigned services (urinalysis, office visit, injections, etc..) and/or fees not covered by your insurance. ϖ If coverage is contingent on a referral of pre-certification, it is your responsibility to inform us. ϖ If you are unable to keep your appointment, we require a 24-hour cancellation notice or your account will be charged $25.oo. We accept cash, check, and the following credit cards: Visa, MasterCard, and Discover. Return checks will be an additional $30.00 fee. Any outstanding account turned over to a collection agency will be charged an additional $35.00 fee.

I hereby authorize After Ours OBGYN, LLC to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees, attorney fees, court costs, or other fees incurred by me.

_____ _____

Patient/Responsible Party Signature Date