PATIENTS NAME: ____

LAST FIRST MI

ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP: __________

HOME PHONE: __________ WORK PHONE: __________ CELL: __________

SOCIAL SECURITY #: ______________________ DATE OF BIRTH: ____/____/____

EMPLOYER: ______________________ DRIVER'S LICENSE #: __________

WHERE DID YOU HEAR ABOUT US? ______________________________

PRIMARY CARE DR/GP: ______________________ PHONE #: __________

PERSONAL EMAIL ADDRESS: ______________________________

PREFERRED PHARMACY:__________ STREETS:__________CITY: __________

SPOUSE'S NAME: ______________________ DOB: ___/___/___ PH #: __________

EMERGENCY CONTACT (other than spouse): ______________________ DOB: ___/___/___

RELATIONSHIP: ______________________PHONE #:__________

**************************************PRIMARY INSURANCE INFORMATION**************************************

INSURANCE COMPANY: ______________________ **PHONE #** __________

CLAIMS MAILING ADDRESS: ______________________________

POLICY # ______________________ **GROUP #** __________

POLICY HOLDER'S NAME ______________________ **DOB** ___/___/___**SS#** __________

POLICY HOLDER'S EMPLOYER: __________**RELATIONSHIP TO PATIENT:** __________

***DO YOU HAVE SECONDARY INSURANCE?** *YES OR NO* **(Circle One)** **Employees Initials* __________

IF YES, WHICH INSURANCE COMPANY? ______________________________

****

REASON FOR YOUR VISIT TODAY? ______________________________

OTHER CONCERNS/COMPLICATIONS: ______________________________

I authorize Jennifer Mushtaler, MD and/or Catherine Browne, DO as the qualified staff to perform upon me, medical care and treatment. I acknowledge that the practice of medicine and/or ultrasound is not an exact science and that no guarantees can be made to me regarding the outcome of treatment and/or my pregnancy.

x PATIENT SIGNATURE: ______________________ **DATE:** __________

I understand the under the Health Insurance Portability and Accountability Act of 1996 I have certain rights to privacy in regards to my private health information. I have read, received a copy (if requested) and understand the Notice of Privacy Practices presented by *Capital ObGyn Associates of Texas, PA.* I acknowledge this practice reserves the right to modify this policy as governed by law and I can request a copy of the policy at any time.

x PATIENT SIGNATURE: ______________________ **DATE:** __________

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to physicians I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to *Capital ObGyn Associates of Texas, PA.*

x PATIENT SIGNATURE: ______________________ **DATE:** __________