

**OB-GYN ASSOC. OF OAK RIDGE, P.C.**

**PATIENT INFORMATION SHEET**

**PAYMENT IS DUE WHEN SERVICES ARE RENDERED (\*INCLUDES CO-PAYMENTS & CO-INSURANCE)**

|                                 |           |         |                                  |                                  |                     |                     |                  |   |     |
|---------------------------------|-----------|---------|----------------------------------|----------------------------------|---------------------|---------------------|------------------|---|-----|
| PATIENT'S NAME - LAST           |           | FIRST   | MIDDLE                           | MAIDEN NAME                      | MARITAL STATUS      |                     |                  |   |     |
|                                 |           |         |                                  |                                  | S                   | M                   | W                | D | SEP |
| AGE                             | BIRTHDATE |         | SOCIAL SECURITY #                |                                  | RACE                | HOME PHONE          |                  |   |     |
| STREET ADDRESS                  |           |         |                                  | CITY                             | STATE               | ZIP CODE            | CELL PHONE       |   |     |
| POST OFFICE BOX                 | CITY      | STATE   | ZIP CODE                         | EMAIL ADDRESS                    |                     |                     |                  |   |     |
| PATIENT'S EMPLOYER              |           |         |                                  | OCCUPATION (INDICATE IF STUDENT) |                     | HOW LONG EMPLOYED ? | BUSINESS PHONE # |   |     |
| EMPLOYER'S STREET ADDRESS       |           |         | CITY                             | STATE                            | ZIP CODE            |                     |                  |   |     |
| SPOUSE OR PARENT'S NAME         |           |         | BIRTHDATE                        | SOCIAL SECURITY #                |                     | PHONE #             |                  |   |     |
| SPOUSE OR PARENT'S ADDRESS      |           |         | CITY                             | STATE                            | ZIP CODE            |                     |                  |   |     |
| SPOUSE OR PARENT'S EMPLOYER     |           |         | OCCUPATION (INDICATE IF STUDENT) |                                  | HOW LONG EMPLOYED ? | EMPLOYEEER PHONE#   |                  |   |     |
| EMPLOYER'S STREET ADDRESS       |           |         | CITY                             | STATE                            | ZIP CODE            |                     |                  |   |     |
| EMERGENCY CONTACT (NOT RELATED) |           | PHONE # | NAME OF NEAREST RELATIVE         |                                  |                     | PHONE #             |                  |   |     |

**DRUG ALLERGIES**

|                             |  |                  |                          |
|-----------------------------|--|------------------|--------------------------|
| PHARMACY NAME               |  | LOCATION         | PHONE #                  |
| REFERRING PHYSICIAN         |  | FAMILY PHYSICIAN | PHONE #                  |
| REFERRING PHYSICIAN ADDRESS |  | PHONE #          | FAMILY PHYSICIAN ADDRESS |

**FINANCIAL INFORMATION**

| PRIMARY INSURANCE                        |                | SECONDARY INSURANCE                      |                |
|--|----------------|--|----------------|
| INSURANCE NAME                           |                | INSURANCE NAME                           |                |
| FILING NUMBER                            |                | FILING NUMBER                            |                |
| GROUP NUMBER                             |                | GROUP NUMBER                             |                |
| SUBSCRIBER'S NAME                        |                | SUBSCRIBER'S NAME                        |                |
| SUBSCRIBER'S BIRTHDATE                   | EFFECTIVE DATE | SUBSCRIBER'S BIRTHDATE                   | EFFECTIVE DATE |
| PATIENT'S RELATIONSHIP TO THE SUBSCRIBER |                | PATIENT'S RELATIONSHIP TO THE SUBSCRIBER |                |

All Professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite Insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. Payment is due for services when rendered unless other arrangements have been made in advance.

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I HEREBY AUTHORIZE OB-GYN ASSOCIATES OF OAK RIDGE, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Date \_\_\_\_\_ Signature \_\_\_\_\_

# OB- GYN ASSOCIATES OF OAK RIDGE, P.C.

## WELCOME TO OUR PRACTICE

Thank you for choosing OB-GYN Associates for your health care needs. Our goal is to provide the very best care and to assure that you are treated professionally and in a timely manner.

## CANCELLATION POLICY

If you must cancel or reschedule your appointment we would appreciate at least a 24 hour notice. There will be a fee if proper notice is not given or for "no show" visits.

## APPOINTMENT TIMES

Please arrive for your appointment at least 15 minutes early to ensure verification of insurance and the proper forms are completed. Please use our website at [www.obgynoakridge.com](http://www.obgynoakridge.com), you can print your demographic forms and follow the link to diglchart from our site. This can be assessed with a username and password that is given to you when you make your appointment. This allows you to enter diglchart and complete your medical history. Electronic medical records are going to be mandatory in the near future and we would like to transition as easily as possible for your convenience. This will save you time in the future.

## TELEPHONE MESSAGE PERMISSION

I, \_\_\_\_\_ give permission to the physicians and staff of OB-GYN Associates of Oak Ridge to leave messages regarding my care in the following manner.

\_\_\_ May leave appointment reminders and lab results on my answering machine

\_\_\_ May leave appointment reminders and lab results \_\_\_\_\_.

\_\_\_ May only leave information with me. **By electing this option it may delay you in receiving critical information**

I prefer to be contacted at \_\_\_ Home \_\_\_ Work \_\_\_ Cell # ( \_\_\_ ) \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- > Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- > Obtain payment from third party payers
- > Conduct normal healthcare operations such as quality assessments and physician certification.

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures on my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

**PATIENTS NAME OR LEGAL GUARDIAN:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_