



Account #

Physician:

Referring Physician:

Your Telephone #

Your Alternative Phone #

Patient Name:

SSN #

Address:

Driver's License #

DOB

Age

Sex

Race

Marital Status: S M W D

Employer's Name

Phone

Address

Spouse's Name

DOB

SSN #

Spouse's Employer

Phone

Notify In Case of an Emergency

Phone

Complete This Section If You Are An Unmarried Minor (under 18)

Father's Name

DOB

SSN #

Father's Employer

Phone

Mother's Name

DOB

SSN #

Mother's Employer

Phone

Parents' Address (If different from your own!)

Insurance Information

Does your Insurance Pay for Routine Annual Exams?

Yes No Unknown

Primary Insurance Company

Insured's Name

Insured Birthdate

Relationship to Patient

Continue



Insured's Employer

Contract #

Group #

Effective Date

Method of Payment: Cash Check Mastercard/Visa

*****Payment is Due at Time of Service.*****

In consideration of services rendered, the undersigned agrees to pay Anniston OB-GYN Associates the charges thereof, insurance notwithstanding. In the event collection action is initiated to collect such charges, the undersigned agrees to pay all costs and expenses of collection, including attorney's fees and court costs. I authorize Anniston OB-GYN Associates to release any medical information relating to my insurance claims. I authorize my insurance company to make direct payment to Anniston OB-GYN Associates for medical services rendered.

By Submitting this form you agreeing to the statement above. You will not be charged nor will your insurance company be charged any amount until the time of service. Which is when payment is due. Thank you for choosing Anniston OB-GYN Associates, P.C.!

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