

## BILTMORE OB-GYN

DATE	<b>PATIENT INFORMATION</b>							
PATIENTS NAME (PLEASE PRINT)	SS#	MARITAL STATUS			SEX		BIRTHDATE	AGE
		S	M	W	D	SEP		
MAILING ADDRESS	CITY AND STATE			ZIP CODE		HOME PHONE #		
HOME ADDRESS	CITY AND STATE			ZIP CODE		CELL PHONE #		
EMAIL	PREFERRED COMMUNICATION <input type="checkbox"/> DECLINED <input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL <input type="checkbox"/> OTHER <input type="checkbox"/> PHONE <input type="checkbox"/> TEXT							
RACE <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> NAT. HAWAIIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> OTHER RACE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WHITE <input type="checkbox"/> DECLINED	PRIMARY LANGUAGE			ETHNICITY		<input type="checkbox"/> UNKNOWN <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NOT HISPANIC/LATINO		
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)					HOW LONG EMPLOYED		
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE		BUS. PHONE # EXT.#		
EMERGENCY CONTACT PERSON	HOME PHONE #			CELL PHONE #				
SPOUSE/PARENT'S(OR) OTHER ASSOCIATED PARTY'S NAME	SS #			BIRTHDATE		HOME PHONE #		
STREET ADDRESS, IF DIFFERENT	CITY AND STATE			ZIP CODE		CELL PHONE #		
EMPLOYER	OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED		BUS. PHONE #		
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE				

**PLEASE ATTACH YOUR CURRENT INSURANCE CARD(S) AND DRIVER'S LICENSE SO WE MAY DUPLICATE THEM FOR OUR RECORDS (THIS ASSISTS US AND YOUR INSURANCE COMPANIES).**

### INSURANCE AUTHORIZATION AND ASSIGNMENT

GENERAL INSURANCE COMPANY (NOT MEDICARE) \_\_\_\_\_

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. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

NAME OF POLICYHOLDER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO BILTMORE OB-GYN FOR ANY SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR THE DEDUCTIBLE, COINSURANCE AND NON COVERED SERVICES. I UNDERSTAND THIS AUTHORIZES RELEASE OF MEDICAL RECORDS AND INFORMATION TO PAY CLAIM.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 PATIENT

IF NOT SIGNING, GIVE RELATIONSHIP TO PATIENT \_\_\_\_\_

MEDICARE SIGNATURE ON FILE \_\_\_\_\_

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS MEDICARE ASSIGNMENT. I UNDERSTAND THAT IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR ANY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 2801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION). REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS ALSO APPLY.

PATIENT'S SIGNATURE \_\_\_\_\_ POLICY # \_\_\_\_\_ DATE \_\_\_\_\_