

Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

SS#: _____ Sex: Male Female Marital Status: Single Married

Street Address: _____ Widowed Other

City: _____ State: _____ Zip: _____ Home Phone: _____

Is this your billing address as well? Yes No

If no, please provide address: _____

Employer: _____ Occupation: _____

Work Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

INSURANCE INFORMATION

Please present your insurance card and driver's license for us to make copies.

Primary Insurance: _____ Address: _____

ID#: _____ Group#: _____ Plan #: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SS#: _____ Relationship to Patient: _____

Effective Date: _____ Amount of Copay: _____

Secondary Insurance: _____ Address: _____

ID#: _____ Group#: _____ Plan #: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SS#: _____ Relationship to Patient: _____

Effective Date: _____ Amount of Copay: _____

CONTACT INFORMATION

Preferred phone number for contacting you about appointments or results: _____

A message may be left at my home Yes No

A message may be left at my place of employment Yes No

A message may be left on my voice mail Yes No

Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) may be identified as the caller. Yes No

Do you have an Advanced Directive? Yes No

Do you have a Living Will? Yes No

EMERGENCY CONTACT: _____ PHONE: _____ Relationship: _____

MINOR/GUARDIAN INFORMATION

If patient is a minor, Parent/Legal Guardian's Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

GUARDIANSHIP AUTHORIZATION: I give _____, my permission to bring my child, _____, to Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) for medical care/treatment. _____ (signature of parent/legal guardian)

I give Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) my permission to evaluate and treat my child, _____, in my absence. _____ (signature of parent/legal guardian)

PLEASE COMPLETE BACK OF FORM

AUTHORIZATIONS

YOU HAVE MY PERMISSION TO DISCUSS MY MEDICAL RECORD INFORMATION AND ACCOUNT WITH THE FOLLOWING FAMILY MEMBERS:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

- I hereby authorize Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) to apply for benefits on my behalf for covered services rendered by the physicians or their orders, realizing that I am responsible to pay for my medical services, any collection agency fees, or attorney fees. I request that payment from my insurance company be made directly to the physician.
- I hereby authorize the release of any pertinent medical information to insurance carriers from Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) or consulting physicians.
- I hereby authorize Alliance Physicians, Inc. (Perinatal Associates of Southwest Ohio) to release pertinent medical information to consulting physicians.
- I certify that the information I have reported with regard to my insurance company is correct. Either my insurance company or I may revoke this authorization at any time in writing.
- I permit a copy of any of these authorizations to be used in place of the original.

Signature: _____ Date: _____
(Patient / Legal Guardian)