Premier
Obstetrics & Gynecology Associates

LOUIS M. COLLAZO, M.D., F.A.C.O.G.
ELIZABETH M. FERNANDEZ, M.D., F.A.C.O.G.
JOANNE M. RICHARDS, M.D., F.A.C.O.G.
EMILIO A. BLANCO, M.D., F.A.C.O.G.

TODAY'S DATE:_____
PRIMARY CARE DOCTOR:_____TEL.( )_____

PATIENT INFORMATION

NAME:_____AGE:_____DOB:____/____/____
ADDRESS:_____APT:___CITY:_____STATE:___ZIP:_____
HOME PHONE:( )_____WORK PHONE:( )_____EXT:_____
CELL PHONE:( )_____OTHER:( )_____
PLACE OF EMPLOYMENT:_____POSITION:_____
SS#_____DRIVER'S LIC #_____
MARITAL STATUS: M S D W SPOUSE'S NAME:_____

****

EMERGENCY CONTACT

NAME:_____HOME PHONE:_____
ADDRESS:_____WORK PHONE:_____
CITY/STATE:_____ZIP:_____RELATION:_____

****

PARENT/GUARDIAN INFORMATION

NAME:_____RELATIONSHIP:_____
EMPLOYER:_____PHONE:_____TITLE:_____

****

PRIMARY INSURANCE

INSURANCE CO:_____
ADDRESS:_____
CIT/ST/ZIP:_____
PHONE #:_____
ID#:_____
GROUP NAME OR #:_____

SECONDARY INSURANCE

INSURANCE CO:_____
ADDRESS:_____
CITY/ST/ZIP:_____
PHONE #:_____
ID#:_____
GROUP NAME OR #_____

IF YOU ARE A DEPENDENT UNDER EITHER OF THE POLICIES LISTED ABOVE, YOU MUST PROVIDE OUR OFFICE WITH THE INSURED SS#, DOB, AND THEIR RELATION TO YOU. FAILURE TO DO SO MAY RESULT IN INSURANCE DENIALS, WHICH ARE YOUR RESPONSIBILITY!

INSURED'S SS#:_____
INSURED'S DOB:_____
RELATION:_____

INSURED'S SS#:_____
INSURED'S DOB:_____
RELATION:_____

INSURED'S PLACE OF EMPLOYMENT:_____

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make payments directly to my doctor and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my doctor. I hereby authorize my doctor to release any information required in the course of examination and treatment.

To avoid misunderstanding regarding medical insurance we wish our patients to know all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare necessary forms to help you obtain benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you along with any collection fee assessed. You will be responsible for any legal fees and interest accruing out of this debt. We also reserve the right to bill any patient that does not show proper proof of insurance, referrals or authorization at the time of service and are subject to the collection fees mentioned above.

Signed Date

****

MEDICARE

Name of Beneficiary_____Medicare#_____

I request that payment of authorized Medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signed Date

****

MEDIGAP

Name of Beneficiary_____Medicare#_____

I request that payment of authorized Medigap benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier any information needed to determine these benefits or benefits payable for related services.

Signed Date

****