

# Lincoln Park OB/GYN

## PATIENT INFORMATION SHEET

|                                 |           |       |                   |                                  |                   |                |                     |                   |   |     |
|---------------------------------|-----------|-------|-------------------|----------------------------------|-------------------|----------------|---------------------|-------------------|---|-----|
| 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 LINCOLN PARK OBGYN, SC. 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 \_\_\_\_\_ How did you hear about us: \_\_\_\_\_