North Park OB-GYN Associated, PC

PATIENT INFORMATION SHEET

DATE:_____

CHECK PROVIDER NAME: ❒ DR. ANDREW R. JONES ❒ DONNA PRELOG, CNM
❒ DR. CHRIS INNES
❒ DR. ERIN SCARBROUGH

LAST NAME:_____ FIRST: _____ MIDDLE: _____

PREFERRED NAME: _____ MAIDEN NAME: _____

PREFIX: ❒ MRS. ❒ MS. ❒ MISS DATE OF BIRTH_____ AGE_____

SOCIAL SECURITY #: _____ MARITAL STATUS:_____

ADDRESS: _____ CITY: _____

ZIP CODE: _____ STATE: _____ COUNTY: _____

HOME PHONE:_____ WORK: _____ CELL: _____

PATIENT EMPLOYER: _____ OR STUDENT STATUS:_____

OCCUPATION: _____ EMAIL: _____

EMERGENCY / SPOUSE / GUARDIAN INFORMATION

NAME:_____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____

EMPLOYER: _____ WORK NUMBER:_____

INSURANCE INFORMATION

INSURANCE CARRIER:_____ MEMBER ID: _____

INSURED'S NAME: _____ RELATION:_____

INSURED'S ADDRESS: _____

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

EMPLOYER NAME: _____ ADDRESS: _____

SECONDARY INSURANCE

INSURANCE CARRIER:_____ POLICY #: _____

INSURED'S NAME: _____ RELATION:_____

INSURED'S ADDRESS: _____

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

EMPLOYER NAME: _____ ADDRESS: _____

AUTHORIZED SIGNATURE IS ON FILE. BY SIGNING I ATTEST THAT ALL INFORMATION PROVIDED IS TRUE AND COMPLETE. MY SIGNATURE AUTHORIZES THE OFFICE TO SUPPLY MEDICAL RECORDS TO MY INSURANCE CARRIER FOR PAYMENT. I UNDERSTAND AND AGREE THAT IF I FAIL TO MEET THE FINANCIAL AGREEMENT OF THIS OFFICE I WILL BE LIABLE FOR ALL COLLECTION COSTS AND ATTORNEY FEES OF 33.3% ADDED TO MY BALANCE. A 2% INTEREST FEE WILL BE ADDED TO MY MONTHLY BALANCE AFTER THE 61ST DAY OF AN UNCOLLECTED BALANCE.

PATIENT SIGNATURE _____ **DATE**_____