For internal use Only
Patient I.D. #

OB/GYN OF FAIRFIELD COUNTY, LLC

Last Name_________________________________ First Name________________________ M.I.___ Maiden/Nickname___________

Street Address____ Apt._____________ P.O. Box_______________

City____ State________________ Zip _________________

SS #________________________ Birth Date ______________________ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other

Home Phone (   ) ________________________ Work (   ) ______________________ Cell (   ) _______________________

MAY WE LEAVE RESULTS ON YOUR CELL PHONE? ☐ **YES** ☐ **NO**

Email Address ____ May we email you? ☐ **YES** ☐ **NO**

Employer Information:

Employer's Name____ Employer Phone ____________________________

Patient's Occupation:____ Student? ☐ Full Time ☐ Part Time

Insurance Information:

Primary Insurance Company Name____

Who is the policyholder for the primary insurance? ☐ Self ☐ Parent ☐ Spouse ☐ Other

Secondary Insurance Company Name____

Who is the policyholder for the secondary insurance? ☐ Self ☐ Parent ☐ Spouse ☐ Other

Spouse or Parent's Information:

Spouse or Parent's Name____ Spouse or Parent's Date of Birth_____________________

Spouse or Parent's SS #_____________________________ Employer's Name & Phone #____________________________________

Emergency Information: List the nearest friend/relative (List a phone number NOT listed above):

Emergency Contact ___________________________________ Phone #_____________________ Relationship ___________________

Other:

Primary Care Physician's Name ____

For Office Use Only:

Authorization for Treatment, Payment and Healthcare Options:

I consent for medical treatment by all providers of OB/GYN of Fairfield County. I authorize the release of medical benefits to OB/GYN of Fairfield County, LLC, its successors and assigns, or any individual it may designate for services provided. As part of this authorization, OB/GYN or Fairfield County, LLC, will release HIV, Drug and Alcohol, and Mental Health/Psychiatric Information as required by law. I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due for services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to OB/GYN of Fairfield County, LLC, its successors and assigns or any individual it may designate for amounts owed by me in accordance with my health benefit coverage.

SIGNATURE OF PATIENT (or Parent of Minor) ____ **DATE** ___________________