GRAPEVINE OBGYN

Welcome! In order to serve you properly, please provide the following information for your physician:

PATIENT INFORMATION

Last name:	First:	M.I.:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Driver's License:	State:	Birth date:	Age:	Religious Affiliation:

Street address:	Social Security no.:	Primary phone: ( )

City:	State:	ZIP Code:	Secondary phone: ( )

Occupation:	Employer:	Employer phone: ( )

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. _____ ☐ Insurance plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary phone: ( )	Secondary phone: ( )

INSURANCE INFORMATION

Please have your insurance card available

Current Insurance Company:
(list secondary also if applicable)

Policy #

Group #

Primary Insured Member information (if person other than patient):

Name:_____ Birth date: Social Security #: Employer:

(Spouse ☐ Parent ☐ _____ ☐)

PAYMENT RESPONSIBILITY/ASSIGNMENT OF BENEFITS/NOTICE OF PRIVACY PRACTICES

The above information is true to the best of my knowledge. I understand there is a fee for services, and I understand the fee is payable at the time services are rendered. I authorize my insurance benefits be paid directly to my physician. I understand that I am financially responsible for any balance not covered by insurance. I also authorize my physician or insurance company to release any information required to process my claims. I acknowledge receipt of "Notice of Privacy Practices."

_____ _____

Patient signature (Guardian if patient is a minor) *Date*