Hahn Ob-GYN Associates

Date: _____

Patient Name (Last,First,MI) _____ Maiden Name: _____

Street Address _____ City _____ ST_____ Zip _____

Best contact number _____ Cell _____ Work _____
(Please circle the best number to reach you at during business hours.)

Date of Birth _____ SS# _____ Pharmacy # _____
PHONE NUMBER

Mail in Prescription Company: _____ Would you like a 90 day supply? Yes – NO
(May not apply to everyone.)

Full time/Part time Student or
Employer or School _____ Occupation _____

Marital Status M S W D – Family Physician _____ Phone # _____

Emergency Contact _____ Relation _____ Phone _____

Spouse/Parent Info: _____ Phone _____
(Person that carries the Insurance)

Street Address _____ City _____ ST_____ Zip _____

Date of Birth _____ SS# _____ Relation to Patient _____

Employer/School _____ Occupation _____

Primary Insurance Company _____
(You will be required to provide card at every visit.)

ID# _____ Group# _____

Name on Policy: _____ Through Employer? Yes – NO

Secondary Insurance Company_____
(You will be required to provide card at every visit.)

ID# _____ Group# _____

Name on Policy: _____ Through Employer? Yes – NO

Payment is expected at time of service unless other arrangements have been made. Please remember you are responsible for all fees, regardless of the insurance coverage.

AUTHORIZATIONS

I authorize the release of medical or other information necessary to process my claims. I authorize payment of medical and surgical benefits directly to my doctor. I understand that I am financially responsible for charges not paid in a timely manner by my insurance. In the event of non-payment, I will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance turned over to an outside agency.

I have read all the above terms and hereby assume responsibility for paying any charges according to these terms.

Signature _____ Date _____

Account # _____