West Augusta Obstetrics & Gynecology, P.C.

New Patient Information Form

Date_____ Doctor_____

Last Name_____ First Name_____ MI_____

Address_____ Apt #_____

City_____ State_____ Zip_____

Date of Birth _____ Social Security_____ Email_____

Phone_____ Cell_____

Employer _____ Work Phone_____ Ext_____

Emergency Contact_____ Relationship_____ Phone_____

Referred by_____ Preferred Pharmacy_____

Spouse/Parent/Insured Information

Last Name_____ First Name_____ MI_____

Address_____ Apt #_____

City_____ State_____ Zip_____ Phone_____

Date of Birth_____ Relationship to Patient_____ Email_____

Insurance Company_____Employer_____

Will you accept a blood transfusion if medically necessary? Yes ( ) or No ( )

Office Policy

1) Payment is due at time of service. A 1.5% service charge will be applied on all balances over 30 days.
2) Patient must inform office staff of all insurance coverage changes at time of service.
3) Medicaid patients' must show current card at time of service. Retro Medicaid will not be filed by our office.

Insurance Authorization and Assignment- I hear by give West Augusta OBGYN permission to furnish information to insurance companies concerning my illness and treatment. I hear by assign all payments for medical services rendered to my dependent or me. I understand I am responsible for any copays, deductibles and amounts not covered by my insurance.

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Patient/Guardian's Signature

For Medicare Patient's only- I request that Medicare payments on my behalf be made to West Augusta OBGYN for all services rendered to me. I authorize approval for my physician to release medical info about me to Centers for Medicare and Medicaid Services as needed to determine benefits and make payments for medical services rendered to me.

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Medicare Patient's Signature