WENDOVER OB/GYN & INFERTILITY
Patient Information

NAME (last, first, middle): ____________________

DATE OF BIRTH: ____________________ SOCIAL SECURITY #: ____________________

LANGUAGE: ____________________ RACE: ____________________

ETHNICITY: HISPANIC OR LATINO __________ NOT HISPANIC OR LATINO __________

ADDRESS: ____________________

____

HOME PHONE #: ____________________ CELL/PAGER #: ____________________

WORK PHONE #: ____________________ EXT #: __________

EMPLOYER: ____________________ OCCUPATION: ____________________

SPOUSE/NEXT OF KIN: ____________________

EMPLOYER: ____________________ PHONE #: ____________________

EMERGENCY CONTACT: ____________________ PHONE #: ____________________

(***PHOTO ID REQUIRED OR GOVERNMENT IDENTIFICATION)

IF STUDENT OR UNDER 18 YEARS OLD:
PARENTS AND/OR PERMANENT ADDRESS: ____________________

____

REFERRED BY: ____________________

I authorize release of any and all medical information necessary to process claims and request payment of benefits to WENDOVER OB/GYN & INFERTILITY, INC. *

____

Signature of patient Date

____

Signature of responsible party if patient is under 18 years of age Date

____

Social Security # of responsible party

* Please be reminded that payment for medical services is the patient's responsibility and this office cannot accept responsibility for negotiating a settlement on a disputed claim. It is the patient's responsibility to obtain prior authorization for services when required by your plan.