Women's Obstetrics & Gynecology, P.C.
115 Technology Drive, Suite A200, Trumbull, CT 06611
140 Sherman St. 5th Floor, Fairfield, CT 06824
Telephone (203) 268-2239 Fax (203) 268-9143

Patients Name: _____
Last name First name MI

Date of Birth: _____ SSN#_____ Marital Status: S/M/W/D

Address: _____

_____

Home Phone: _____Cell: _____
Please indicate best phone number to reach you or leave you a message. Messages may include medical information, test results or personal information:

Employer: _____Work: _____

Work Address: _____Occupation: _____

Emergency Contact: _____Phone: _____Relationship: _____

Insurance: _____ID#_____

Preferred Pharmacy and location:_____

Primary Care Physician:_____

Email address:_____

Referred by:_____

Primary Language:_____Secondary Language:_____

Race:_____Religion:_____Organ Donor:_____

Authorization for payment and release of information: I hereby authorize my insurance benefits be paid directly to Women's Obstetrics and Gynecology, P.C. and its medical care providers. I also authorize to release medical information necessary to process the insurance claims for medical benefits. I further agree to pay costs of collections, including attorney's fees, associated with collection of any amount due to services rendered and performed. I will pay interest at the 18% annual rate for all amounts 30 days past due. I understand that I am financially responsible to Women's Obstetrics and Gynecology, P.C. for amounts owed to me in accordance with my health benefit coverage. I understand that I will pay all outstanding balances prior to the release of medical records to outside parties (including other medical offices, attorneys, insurance companies etc). With more healthcare costs paid directly by patients, it is mandatory to provide us with a credit card for our file to be used for outstanding balances. I am responsible to understand my insurance benefits as they relate to services provided by Women's Obstetrics and Gynecology, P.C.

Patients Signature: ____Date: __________