Ob-Gyn Specialists
A division of BASS Medical Group
women caring for women

PATIENT INFORMATION RECORD

Date: ____________________ Social Security Number __________ - _______- __________

Email Address ______________________________ Pharmacy____

Patient's Name: ____
Last Name First Middle

Preferred Name: ____

Date of Birth: ____________________ Marital Status: ☐ S ☐ M ☐ W ☐ D Age _________

Race:__________________________ Are you Hispanic? __Yes __No

Language:__________________________ Religion:_________________________/or ☐ Declines to specify

Street Address: ____ City:____________________________________

State/Zip Code: ____________________________________ Home Phone #: (_______) ___________ -- ___________

Cell Phone #: (_________) ___________ -- _____________ Driver's License#:________________________________

Patient's Employer: _______________________________ Work Phone #: (________) ____________ -- __________

Spouse's Name: _________________________________ Spouse's SS# ___________________________________

Spouse's DOB: _________________________________ Spouse's Phone #: _______________________________

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: ____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other* DOB of Insured:________________________

* if other, please provide insured's name: ____

SECONDARY INSURANCE CARRIER:

____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other* DOB of Insured:________________________

* if other, please provide insured's name: ____

If patient is a Minor, are parents ☐ Married ☐ Divorced Custodial Parent _________________________________

Custodial Parent's Home Phone: (_______) _______ -- _________ Work Phone: (_______) ________ -- _______

Custodial Parent's SS #: _____________________________ Date of Birth: ___________________________________

PHYSICIAN INFORMATION

Referring Physician's Name:_____________________________________ City: ____________________________________

Primary Care Physician: ____ City: ____________________________________

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: ____

Phone #: (_______) __________ -- ___________ Relationship to Patient: _________________________________

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize OB-GYN Specialists, Inc. to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to OB-GYN Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at OB-GYN Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

_______________________________________ Signature of Patient, Parent or Legal Guardian

_______________________ Relationship to Patient

____________ Date

_______________________________________ Patient's Signature

_______________________________________ Patient's Printed Name

_______________________________________ Today's Date