How do you wish to be called? By your first name Mrs. Ms.

Today's Date _____ Marital Status S M D W

Patient Name_____

Address_____ Spouse's name _____

City, State, Zip _____

Date of Birth _____ Name of person to be called in an emergency

Social Security # _____ _____

Telephone # _____ Relationship _____ Phone # _____

Cell phone#_____ Family Physician_____

Employer _____ Referred by _____

Work phone #_____ Email address_____

MEDICARE PATIENTS

****Please have your insurance card (s) ready to give the receptionist ****

Do you have Medicare Part B? yes no (if no, please continue to primary insurance)

Medicare #_____

Do you have Medicare Gapover yes no (if you are not sure, please skip this question)

Is Medicare your primary insurance? yes no

Do you have secondary insurance? Yes no (if yes, please fill out secondary insurance)

PRIMARY INSURANCE

Insurance company _____ Name of policy holder _____

Address _____ Policy holder's SS#_____

City, State, Zip_____ Policy Holder's Date of Birth _____

Telephone #_____ Relationship to you _____

Insurance ID# _____ Policy holder's employer_____

Insurance group name/number_____

SECONDARY INSURANCE

Insurance company _____ Name of policy holder _____

Address _____ Policy holder's SS#_____

City, State, Zip_____ Policy Holder's Date of Birth _____

Telephone #_____ Relationship to you _____

Insurance ID# _____ Policy holder's employer_____

Insurance group name/number_____

I authorize the release of any information necessary to process insurance claims. I authorize payment of benefits directly to WGM Obstetrics & Gynecology, PC. I authorize WGM Obstetrics & Gynecology, PC to submit claims for services rendered without obtaining my signature on each and every claim submitted. I understand that certain charges may not be covered by medical insurance, and I am financially responsible for all charges incurred.

Signed _____ Date _____