Brookside Greenwich Obstetrics & Gynecology Associates

Patient Information

Last Name _____ First Name _____ M.I. _____

Street Address _____ Apt. _____ P. O. Box _____

City _____ State _____ Zip _____ Birth Date _____

Soc. Sec. # _____ Maiden Name _____

Home Phone _____ Work Phone _____ Cell _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner ❑ Other

E-Mail Address _____ May we e-mail you? ❑ Yes ❑ No

Responsible Party (to whom bills should be mailed—if patient, write "same")

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Relationship _____ DOB _____ Soc. Sec # _____

Employer Information

Employer Name _____ Employer Phone Number _____

Employer Address (street, city, state, zip) _____

Occupation _____ If student: ❑ Full Time ❑ Part Time School _____

Insurance Information – Primary / Secondary

Primary Insurance _____ **Copy of Card ❑ Yes ❑ No**

Subscriber _____ Relationship _____

Secondary Insurance _____ **Copy of Card ❑ Yes ❑ No**

Subscriber _____ Relationship _____

Spouse's or Parent's Information (If patient is covered by Spouse's / Parent's Insurance)

Name _____ Birth Date _____ SS# _____

Employer _____ Employer Phone _____

Employer Address (street, city, state, zip) _____

Emergency Contact

In case of an emergency we may contact:

Name: _____ Phone: _____ Relationship: _____

Privacy Information

May we call you at your:			May we leave a message:		
Home Phone	❑ Yes	❑ No	Home Phone	❑ Yes	❑ No
Cell Phone	❑ Yes	❑ No	Cell Phone	❑ Yes	❑ No
Work Phone	❑ Yes	❑ No	Work Phone	❑ Yes	❑ No

Do we have permission to mail pathology/lab results & reminders to your home address: ❑ Yes ❑ No

If no, please provide mailing address: _____

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Brookside Greenwich Obstetrics & Gynecology Associates, P.C., its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Brookside Greenwich Obstetrics & Gynecology Associates, P.C. will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all costs, including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Brookside Greenwich Obstetrics & Gynecology Associates, P.C., its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____

Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations
Medicare Recipients sign both Authorizations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Brookside Greenwich Obstetrics & Gynecology Associates, P.C. for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____

Patient's Signature Date

Notice of Privacy Practices: ❑ Received ❑ Refused _____

Signature of patient or parent of minor Date

May release protected health information to: _____ Relationship _____