

Augusta OBGYN, PC

New Patient Information Sheet (Informacion del Paciente)

Please fill out all questions as completely as possible. If you have any questions, please ask the receptionist for assistance. Thank You. (Por Favor llene este cuestionario)

Date (fecha) _____ Doctor _____ Referred By (Referido por) _____

Patient Information (Informacion del Paciente)

Nick Name: _____

Name (Nombre) _____ Date of Birth (Fecha de Nacimiento) _____

Address (Direccion) _____

City & State (Ciudad & Estado) _____ ZipCode _____

Home Area Code & Phone Number (No. de telefono de casa) _____

Daytime Area Code & Phone Number (No. de telefono de casa) _____

Mobile Area Code & Phone Number (No. de telefono de casa) _____

Email address _____

Social Security Number (No de Seguro Social) _____ Age (Edad) _____

Marital Status:

Married (Casada) ___ Widowed (Viuda) ___ Divorced (Divorcida) ___ Separated (Separada) ___ Single (Soltera) ___

Husband or Guarantor Information (Informacion del Paciente)

Name (Nombre) _____ Social Security Number _____

Address (Direccion) _____

City & State (Ciudad & Estado) _____ ZipCode _____

Employer Information:

Employer's Name _____

Employer's Address (Direccion) _____

Employer's City & State (Ciudad & Estado) _____ ZipCode _____

Employer's Area Code & Phone Number (No de telefono de Trabajo) _____

Race: White ___ Hispanic ___ Black ___ Asian ___ Other ___

Emergency Contact Information

Emergency Contact Name _____

Emergency Area Code & Phone Number (No. de telefono de casa) _____

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Parent Information (if patient is a minor) [Information del parientes]

Name (Nombre) _____ Date of Birth (Pecha de Nacimieto) _____

Address (Direccion) _____

City & State (Civdad & Estado) _____ ZipCode _____

Home Area Code & Phone Number (No. de telefono de casa) _____

Relation to Patient _____

Employer's Name _____

Employer's Address (Direccion) _____

Employer's City & State (Civdad & Estado) _____ ZipCode _____

Employer's Area Code & Phone Number (No de telefono de Trabajo) _____

Social Security Number (No de Seguro Social) _____ Age (Edad) _____

Insurance Information:

Primary Insurance Company _____

Policy Number/Identification Number _____ Group No. _____

Secondary Insurance Company _____

Policy Number/Identification Number _____ Group No. _____

I authorize the release of any medical information necessary to process this claim.

Patient's or Authorized Representative's Signature Date

I authorize payment of medical benefits to undersigned physician for all medical services provided.

Patient's or Authorized Representative's Signature Date

I understand that payment is due for any non-covered services at time of service unless prior arrangements have been made.

Patient's or Authorized Representative's Signature Date