

# CELEBRATION OBSTETRICS AND GYNECOLOGY

A MEDICAL PRACTICE DEDICATED TO WOMEN'S HEALTH

410 CELEBRATION PLACE, SUITE 208

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## PATIENT INFORMATION:

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARTIAL STATUS: SINGLE MARRIED OTHER

SOC. SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

CELLULAR PHONE: \_\_\_\_\_ PATIENT'S OCCUPATION: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE'S FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SPOUSE'S OCCUPATION: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? \_\_\_\_\_ PHONE : \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION:

NAME OF PERSON RESPONSIBLE FOR INSURANCE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SOC. SEC.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_ CARD ID #: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, (OR MY DEPENDENT) HAS INSURANCE COVERAGE WITH \_\_\_\_\_  
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO CELEBRATION OBSTETRICS AND GYNECOLOGY ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. IN CASE AN ACTION IS INSTITUTED TO COLLECT THIS NOTE OR ANY PORTION THEREOF, THE BELOW NAMED PATIENT PROMISES TO PAY ALL COLLECTION COSTS AND ADDITIONAL SUMS AS MAY BE DEEMED RESPONSIBLE IN SAID ACTION, I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
DATE