Hilltop Obstetrics & Gynecology, Inc.
PATIENT INFORMATION

Patient Demographics (Please print)

Name (First)__________________________(MI)_______(Last)________________Date of Birth:_________________Age:_____________

Address:____City____________________State_________ Zip_______________

Home Phone:(_________)__________________________ Work #:(______) ________________Alt/Cell #:(_____) ____________________

Social Security #:__________________Marital Status:____S ___M ___D ___W Maiden Name:______________________________

Patient's Employer:_______________________Occupation:__________________PT___FT___Self___Retired___Active Duty___

Mother's Maiden Name:__________________________Student Status:_____Full-time ________ Part-time ________Not a student

Spouse's Name:_____________________________ Spouse SS#:_____________________Spouse's Employer:____________________

Contact in Case of Emergency:____________________________________ Phone #:____

Do you have a Living Will or Advance Directive? ___ Yes ___ No
If yes, please specify document/provide to office____

Primary Care Physician:____ Telephone #:_____________________________________

How did you hear about us? ___Yellow pages ____Newspaper/magazine ad____physician ____ Other___________________

Insurance Information: (Please print)

Primary Insurance:____Phone #:____
Insurance Address:____
City:_____________________________________State:______________________ Zip:_______________________________________
Subscriber:_____________________________Date of Birth:_________________ Relation to patient:__________________________
Policy ID#_____________________________________Group #____
Subscriber's SSN#:____________________________________ Subscriber's Employer_______________________________________

Secondary Insurance:____ Phone #:____
Insurance Address:____
City:_____________________________________State:______________________ Zip:_______________________________________
Subscriber:_____________________________Date of Birth:_________________ Relation to patient:__________________________
Policy ID#_____________________________________Group #____
Subscriber's SSN#:____________________________________ Subscriber's Employer_______________________________________

If Patient is a Minor:

Mother's Name:_______________________________________Date of Birth:______________Home Phone #:____________________
Mother's Employer:___________________________________Bus. Phone #________________SSN#:___________________________
Father's Name:_______________________________________Date of Birth:______________Home Phone #:____________________
Father's Employer:___________________________________Bus. Phone #________________SSN#:___________________________

Please read and sign below:

I hereby authorize Hilltop Obstetrics & Gynecology, Inc. to release any and all information concerning my illness and treatments to insurance companies, referring physicians, and/or other specified interested parties and assign benefits to my physician that may otherwise be payable to me for services rendered to myself or my dependents. I understand that by signing this document, I am responsible for any balances due that are not paid by insurance for the patient identified herein. I understand that a copy of this authorization shall be treated as an original. I understand that my personal health information may be used for general healthcare operations including, but not limited to treatment and payment. Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a) (1) of the Medicare law.

Signature of Patient or Guarantor:____Date:__________________