WEST OAKLAND OB/GYN
REGISTRATION & INSURANCE INFORMATION

Account No: ____________
Today's Date: ____________

Please Print

PATIENT INFORMATION

Last Name ______ First Name ______ M.I. ______ Birth date ___/___/___ Driver's License # ______

Address ______ City ______ State ______ ZIP ______ Religious Preference ______

Social Security ______

Marital Status
__ Single
__ Married
__ Divorced
__ Widowed
__ Separated

Home Phone ______

Cell Phone ______

Work Phone ______

Circle preferred daytime contact #:
home / cell / work / other______

Leave message on machine? Yes _____ No_____

Message with household member? Yes No

EMPLOYER INFORMATION

Employer ______ Occupation ______

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Last Name ______ First Name ______ M.I. ______ Birthdate ___/___/___ Sex ______

(Address if different from Patient) ______ City / State ______ Phone ______

Social Security Number ______ Employer ______

EMERGENCY CONTACT: (Name, Address, and Telephone Number of Emergency Contact or Nearest Relative NOT with you):

____

REFERRED BY: Physician Referral/PCP - Dr. ______ Friend/relative(name)______

Insurance:______ Other:______

PHARMACY NAME: ______ Pharmacy Phone:______

INSURANCE INFORMATION

Blue Cross & Blue Shield:
PPO/HMO/POS/Traditional (please circle)

Subscriber______

Group No: ______

Contract No: ______

Medicare:

ID NO: ______

Other Insurance: HMO/PPO/POS

Insurance Co. Name______/______
Phone

Subscriber:______

ID Number:______

Group No: ______/Employer______

______
Patient Signature Date

FOR ALL PATIENTS

I agree that I shall be legally responsible for any medical or surgical charge incurred in excess of any health insurance benefits that might be applicable.

I assign payment of authorized benefits to West Oakland OB/GYN and William Beaumont Hospital on my behalf for services rendered through West Oakland OB/GYN Clinic and the Professional Services Divisions of William Beaumont Hospital /Beaumont Reference Lab. I understand that I am responsible for the charges not covered by my policy.

RELEASE OF INFORMATION:
I authorize West Oakland OB/GYN to release any medical information required by my health insurance company to process a claim, according to HIPAA regulations.

CONSENT TO TESTING:
In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissues or products and I consent to this. I understand that if it becomes necessary will be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS). I will be counseled by my physician and will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable diseases is not required by law in situations where a health care provider sustains an exposure to my

PRIVACY POLICY:
I acknowledge that I have been given the opportunity to review West Oakland OB/GYN's Notice of Privacy Practice: Policy according to HIPAA federal regulations. I am further aware that I can request, in writing, modifications according to my personal preferences to this policy.

______________________________	______________________	____________
Signature of Patient or Legally Authorized Representative	Witness	Date

FOR MEDICARE PATIENT ONLY

I request payment of authorized Medicare benefits to either myself or West Oakland OB/GYN on my behalf for services rendered through West Oakland OB/GYN and the Professional Services Division of William Beaumont Hospital / Beaumont Reference Laboratory. I authorize the holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

____
Patient's Signature