



PATIENT INFORMATION									
NAME (Last, First Middle)					SSN#		BIRTHDATE		SEX
LOCAL ADDRESS				CITY, STATE, ZIP			SECONDARY/BILLING ADDRESS (If applicable)		
HOME PHONE			CELL PHONE			CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS	SMOKER?(Y/N)	VETERAN? (Y/N)	PRIMARY CARE PROVIDER			EMAIL ADDRESS		
CONTACT NAME AND PHONE NUMBER (PERSON NOT LIVING WITH YOU)						WHO REFERRED YOU TO OUR OFFICE?			
WITH WHOM MAY WE DISCUSS YOUR MEDICAL INFORMATION? (PLEASE WRITE OUT SPOUSE, PARENT, ONLY ME, OR OTHER NAME)									
PATIENT EMPLOYER					SPOUSE EMPLOYER				
ADDRESS					ADDRESS				
CITY, STATE, ZIP					CITY, STATE, ZIP				
WORK PHONE			OCCUPATION		WORK PHONE			OCCUPATION	
RESPONSIBLE PARTY INFORMATION (If different from above)									
NAME (Last, First Middle)					SSN#		BIRTH DATE		SEX
LOCAL ADDRESS				CITY, STATE, ZIP			SECONDARY/BILLING ADDRESS (IF APPLICABLE)		
HOME PHONE			CELL PHONE		WORK PHONE		CITY, STATE, ZIP		
MARITAL STATUS	STUDENT STATUS	SMOKER?(Y/N)	VETERAN? (Y/N)	PRIMARY CARE PROVIDER			EMAIL ADDRESS		
RELATIONSHIP TO PATIENT					EMPLOYER / OCCUPATION				
PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY						POLICY #			
NAME OF INSURED						GROUP#			
ADDRESS OF INSURANCE COMPANY						COPAY AMOUNT			
CITY, STATE, ZIP				PHONE #		DEDUCTIBLE			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE			EXPIRATION DATE			
SECONDARY INSURANCE (If Applicable)									
NAME OF INSURANCE COMPANY						POLICY #			
NAME OF INSURED						GROUP#			
ADDRESS OF INSURANCE COMPANY						COPAY AMOUNT			
CITY, STATE, ZIP				PHONE #		DEDUCTIBLE			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE			EXPIRATION DATE			



NAME (Last, First Middle)	SSN#	BIRTHDATE
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I understand that Drs. Goodman & Partridge, OB/GYN PLLC participates in many insurance plans. If I am not sure if my insurance is one of those accepted, I should call my plan and inquire if Drs. Goodman & Partridge are part of my network. I understand that it is my responsibility to get any needed referrals before my visit. I understand that it is my responsibility to know and understand my benefits and coverage. I understand that I may request a refund of any credits on my account once all claims have been processed and paid.

I understand that all professional services rendered are charged to me, and that I am responsible for all fees, regardless of insurance coverage. I understand that it is customary for payment to be made when services are rendered unless other arrangements have been made in advance with an office manager. I understand that all co-pays are expected before being seen. I understand that reasonable late fees or collections fees may be assessed in the event of late payment or non-payment of balance.

I request that payment of authorized Medicare/insurance company benefits be made either to me or on my behalf to Drs. Goodman & Partridge, OB/GYN PLLC for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provide penalties for withholding this information.)

I have read and have been offered a copy of the Notice of Privacy Practices for Protected Health Information.

SIGNATURE _____

DATE _____