Hamburg Regional Gynecology

Patient Information

Last Name	First Name	Middle Initial	Date of birth
_____	_____	_____	_____/_____/_____

Mailing address: CITY, STATE AND ZIP CODE	Home phone
_____	_____

Cell phone	Work phone	Social security number
_____	_____	_____

Primary MD	Pharmacy Name/location	Employer Name
_____	_____	_____

Ethnicity status (please circle one)
Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Patient declined to answer

Race (please circle one)
White Black/African American Asian Native American
Hawaiian/Pacific Islander Other Patient declined to answer

Insurance Policy Holder (person who carries insurance policy)

Self Spouse Parent (Please circle one)	Last name	First name
	_____	_____

Social security number	Date of birth	Phone
_____	_____/_____/_____	_____

_____
Mailing address (please include Apt # and or PO Box), CITY, STATE AND ZIP
COPY OF INSURANCE CARD AND DRIVERS LICENSE

Please note: For all insurance companies with whom Hamburg Regional Gynecology is NOT a participating provider, for providers that deem your exam NOT MEDICALLY NECESSARY, or if a preauthorization and/or a referral are required and is not obtained, or is incorrect the guarantor is ultimately responsible for full payment of the account, INCLUDING outside collection costs.
I understand I am responsible for all patient charges and hereby authorize release of information regarding the services rendered for payment of insurance benefits directly to Hamburg Regional Gynecology.

Patient Signature	Date
_____	_____