Welcome to University Obstetrics & Gynecology!

Name of PCP:________________________ PCP Phone:_________________ PCP Fax:__________________

Check one: _____ Established Patient _____ New Patient

Whom may we thank for referring you to our office: ____

Patient Name (Last, First, Middle) : ____

Date of Birth: _____________ Age: ______ Social Security No.: ________________ Race: ________________

Marital Status (circle one): Married / Single / Divorced / Widowed / Separated

Home Address (incl. zip code): ____

Primary Email Address: _______________________ Home Phone Number: ____________________________

Employer: ______________________________________ Work Phone: ___________________________

Employer Address: ____ Occupation: _________________

Emergency Contact Information

Contact Name: _____________________________________ Relationship: ___________________

Address (incl. zip code): ____

Home No. (incl. area code): _________________ Work: _________________ Other: ________________

Insurance Information

Primary Insurance

Company Name: __________________________________ Phone (incl. area code): _________________

Insurance Address: ____

Policy ID Number: _________________________________ Group Number: _______________________

Policy Holder Name (last, first, middle): ____

Date of Birth: ________________ Address (if different): ____

Employer: _____________________________________ Work Phone: ___________________________

Relationship to Policy Holder: _________________________

Secondary Insurance

Company Name: ________________________________ Phone (incl. area code): _______________________

Insurance Address: ____

Policy ID Number: _________________________________ Group Number: ____________________________

Policy Holder Name (last, first, middle): ____

Date of Birth: ________________ Address (if different): ____

Employer: _____________________________________ Work Phone: _______________________________

Relationship to Policy Holder: _________________________

Primary Care Physician: ______________________________ Referred By: _____________________________

Other Physicians: _____________________________________Pharmacy Phone Number: ________________

I certify that the above is true and correct to the best of my knowledge. I understand it is my responsibility to notify the doctor's office of any changes to the above information. I accept full financial responsibility for any charges which occur secondary to insurance not being correctly billed (Example: Secondary insurance not provided or billed).

____________________________________ ______________________

Signature of Patient or Representative Date

CONSENT FOR MEDICAL CARE, AND RELEASE OF RECORDS

I give my permission for medical care, including the recording of my medical history, physical examination, laboratory tests, and x-ray films; any of which may help evaluate my conditions, plan treatment, or evaluate its results.

I have been informed that written and computerized records regarding my illness, treatment, and follow-up will be kept by my John S. Weitzner, MD, FACOG, and his staff. I also understand that computer access to and/or copies of these records which may include pathology slides, x-rays and associated reports may be provided to authorized medical personnel at affiliated institutions where I may continue my treatment.

I am aware of the fact that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in terms of treatment or examination.

My medical records may be used by my insurance carrier for audit as well as billing purposes to improve the efficiency and quality of healthcare.

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Patient Name or Representative (Please Print)

______________________________________ ________________

Patient or Representative Signature Date