

## North Florida OB GYN LLC

**Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.**

Social Security \_\_\_\_\_ Patient \_\_\_\_\_  
(Last) (First) (Middle Initial)

Date of Birth \_\_\_\_\_ Address \_\_\_\_\_  
(Street #) (City) (State) (Zip)

Home Tel#: \_\_\_\_\_ Work Tel#: \_\_\_\_\_ Patient Cell # \_\_\_\_\_

Employer \_\_\_\_\_ Patient E-Mail \_\_\_\_\_ Marital Status \_\_\_\_\_  
(S M D W Sep)

Employment Status \_\_\_\_\_ (FT PT Ret N/A) Student \_\_\_\_\_ (FT PT)

How did you hear about our office? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Spouse's name or other responsible party: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Name, Phone #, Fax # and address \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Subscriber (Insured) Name \_\_\_\_\_

Subscriber: Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group Name & # \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_  
(Self, Spouse, Child)

Insurance Address \_\_\_\_\_  
(City) (State) (Zip)

**Second Insurance:** \_\_\_\_\_ Subscriber (Insured) Name \_\_\_\_\_

Subscriber: Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group Name & # \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_  
(Self, Spouse, Child)

Insurance Address \_\_\_\_\_

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record. To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on **02/26/2014**. I acknowledge that I have read this authorization and fully understand its contents.

Signature \_\_\_\_\_ Date \_\_\_\_\_