A Patient Update Information Office Uses EMR

Please review the following information. PLEASE NOTE INFORMATION ABOUT EMAIL ADDRESS. **If this information is not current, please update your information in the space to the right**. When completed, please sign and return to our check-in window.

How would you like to be contacted?

Employer:
Home Telephone # Cell Phone:
Work Telephone:
Emergency contact: Phone #
Marital Status: Single Spouse's Name
Patients Email Address if over 18:
(If your email address is provided, you may register on our patient portal and we will use it as your preferred method of notification for appointment reminders and in office lab results. We cannot accept a minor child's email address, unless they are pregnant.)
DOB:
Social Security Number:
Primary Care Doctor:
Referring Doctor:
Pharmacy & Location: Phone

Primary Insurance Information:
Subscriber's Name: Relationship to insured: Self, Spouse or Child
Insurance I.D. Number:
Group Number:
Group Name:
Date of Birth of Policy Holder:
Policy Holder's Social Security #: ______________________________
Policy Holder's Employer: ______________________________

Secondary Insurance - Subscriber's Name:
If the subscriber is not the patient – what is the relationship to patient: Spouse or Parent?
Date of Birth of Policy Holder:
Policy Holder's Social Security #: ______________________________
Policy Holder's Employer: ______________________________

If there are any changes in your insurance information, please supply us with a copy of your insurance card. Failure to notify us of a change in your insurance will make you responsible for any lab charges incurred.

For the services rendered by North Florida OB GYN LLC, I hereby authorize the release to my health insurance company any information acquired, including the diagnosis and records in the course of my examination or treatment to process claims. I also request payment of government benefits either to myself or the party who accepts assignment. I understand this office employs a Nurse Practitioner (ARNP) Nurse 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 also consent to electronic access to my medication history.

Patient Signature ______________________________ Date ______________________