

**PATIENT INFORMATION SHEET**

Moscow-Pullman OB-GYN

**PATIENT NAME** \_\_\_\_\_ **SOCIAL SECURITY #** - \_\_\_\_ - \_\_\_\_Age \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Work/Message (\_\_\_\_) \_\_\_\_\_ Cell phone/other (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Spouse's name \_\_\_\_\_ Spouse's social security # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**BILLING ADDRESS (If different from above)**

c/o Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**STUDENTS AND MINORS**

Father's name \_\_\_\_\_ Mother's name \_\_\_\_\_

Father's address \_\_\_\_\_ Mother's address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Father's phone (\_\_\_\_) \_\_\_\_\_ Mother's phone (\_\_\_\_) \_\_\_\_\_

Father's employer \_\_\_\_\_ Mother's employer \_\_\_\_\_

Father's occupation \_\_\_\_\_ Mother's occupation \_\_\_\_\_

Father's work phone (\_\_\_\_) \_\_\_\_\_ Mother's work phone (\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Cell/other phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

Primary insurance \_\_\_\_\_ Secondary insurance \_\_\_\_\_

**\*\*\*MOST OF YOUR LAB WORK WILL BE BILLED TO YOU BY OUTSIDE LABORATORIES\*\*\*****MEDICAL RELEASE:** I authorize any holder of medical information about me to release to my insurance companies and their agents any information needed to determine benefits or the benefits payable for related services.**ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT:** I, the undersigned, authorize payment of medical benefits to be made directly to Devlin & Huberty, P.S. I agree to pay my portion at the time services are rendered. I understand that my visit will be billed to my insurance if I have provided copies of my insurance cards. I understand and agree that (regardless of my insurance status) I am ultimately responsible for payment of any professional services rendered. I also understand a finance charge will be added to each charge on my account that has not been paid within 60 days. (No finance charge will be added to charges that are waiting payment from your insurance company.) The FINANCE CHARGE will be computed at the rate of 1.5% per month or an ANNUAL PERCENTAGE RATE of 18% with the exception of Medicare which, by law, cannot be assessed finance charges.**I have read and understand the above release and assignment of benefits.****PATIENT'S SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_*(If patient is a minor, the parent or guardian must also sign below.)***PARENT/LEGAL GUARDIAN SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_