



# Bedford Commons OB-GYN, P.A.

## Patient Information Sheet

(Please Print)

If you are new to our practice:

How did you find out about us?

### We like to thank our referrals.

- Another patient of Bedford Commons \_\_\_\_\_
- Facebook
- Hospital Emergency Room \_\_\_\_\_
- Insurance listing: \_\_\_\_\_
- Newspaper/Magazine ad \_\_\_\_\_
- Yellow pages

### Please specify their name below: Referred by:

- Attended a "Regarding Women's Health" talk
- Community Event (Expo, etc.) \_\_\_\_\_
- I previously was a Bedford Commons OB-GYN patient
- Internet Search site: \_\_\_\_\_
- Physician (Please complete box below)
- Other: \_\_\_\_\_

### Referring Physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Specialty: \_\_\_\_\_

Is this your primary care physician?

Yes                  No

### Personal Information:

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

First                  MI                  Last

Marital Status: (Please circle) S M Sep W D

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

Work #: \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_

### Insurance Information:

#### Primary Insurance Company Information

Insurance Name: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Effective Date: \_\_\_\_\_

Subscriber Responsible for Insurance: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Address of Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Phone # for Subscriber: \_\_\_\_\_

Subscriber's Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_

#### Secondary Insurance Company Information

Insurance Name: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Effective Date: \_\_\_\_\_

Subscriber Responsible for Insurance: \_\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_

Address of Subscriber: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Phone # for Subscriber: \_\_\_\_\_

Subscriber's Work #: \_\_\_\_\_ Ext.: \_\_\_\_\_

\* Please provide us with a front and back copy of your Insurance card so we can properly submit a claim to your insurance carrier.

**Signature Needed -- See Reverse Side**

## CANCELLATION OR NO SHOW POLICY

*If you need to cancel or reschedule your appointment with us, please notify us at least 24 hours prior to your appointment time. **Due to our extensive waiting list, patients who do not give us the required notice will be charged \$50. Also, if you arrive late for your appointment, we cannot guarantee that you will be seen.***

### **PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:**

I, the undersigned, consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Bedford Commons Ob-Gyn, P.A., (BCOG). For those insurance plans for which BCOG accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. I authorize payment directly to BCOG for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

To our Managed Care Patients: Your signature below indicates that if you receive any services at Bedford Commons, Ob-GYN, P.A. and the fees are denied because you did not obtain prior approval from your Primary Care Physician, you will be personally responsible for those fees.

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Signature of Patient or Parent/Legal Guardian

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Date