ALL BLANKS MUST BE COMPLETED

Last_______________________ **First**_______________________ **Middle**_______________________

Address_______________________ **City/State**_______________________ **Zip Code**_______________

Home #_______________________ **Work #** _______________________

Your Emergency Contact - (not living with you) Name & Phone_______________________

Your Age_______ **Your Date of Birth**_____________ **Your Social Security #**_______________ **Marital Status M S W D**

Employer Name_______________________ **Address**_______________________

Cell #_______________ **Family Physician or Internist**_______________________

Primary Insurance - This information pertains to the policyholder.

Name of Insurance Co._______________________ **Phone #**_______________________

Insurance Co. Address_______________________

Policy / ID #_______________________ **Group #**_______________________ **co pay amount $**___________

Employer_______________________

Policyholder's Name_______________________ **Policyholder's Date of Birth**_______________________

Policyholder's Social Security #_______________________ **Relationship to Patient**_______________________

Secondary Insurance - This information pertains to the policyholder.

Policyholder's Name_______________________ **Relationship to Patient**_______________________

Policyholder's Date of Birth_______________________ **Policyholder's Social Security #**_______________________

Policy / ID #_______________________ **Group #**_______________________ **co pay amount $**___________

Employer_______________________

Name of Insurance Co._______________________

Insurance Company Address_______________________

Phone #_______________________

Who is responsible for payment today and any remaining balance?

Name_______________________ **Relationship to Patient**_______________ **DOB**_______________

Address if different_______________________ **Phone # if different**_______________________

Employer_______________________ **Employer phone #**_______________________

Parent or Spouse's Employment

Parent or Spouse's Name_______________________ **Employer**_______________________

Employer address_______________________ **Phone #**_______________________

Please Remember:

1. Our charges are due at the time services are performed.
2. Payment is your obligation regardless of insurance or third party involvement unless we are a participating member of your PPO or HMO.

Assignment and Release: I authorize payment of insurance benefits to be paid directly to Hendersonville Obstetrics and Gynecology. I also authorize Hendersonville Obstetrics and Gynecology to release any information required to process the claim. I further understand and agree that if the accounts for which I am responsible become delinquent, I will pay for all costs associated with the collection process. These may include, but would not be limited to collection fees, attorney's fees and court costs.

Signature_______________________ Date_______________ Employee's Initials_______________