



OBSTETRIC AND GYNECOLOGIC ASSOCIATES OF COLUMBUS, P.C.

2000 HAMTON ROAD COUMBUS, GEORGIA 31904-8927

OB/GYN Associates Of Columbus, PC

2000 Hamilton Rd
Columbus, GAS 1904
(706) 324-4891

PATIENT INFORMATION			
NAME (Ust, First Middle)	MRN	SSN#	I BIRTHDATE SEX I
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)		
CITY. STATE ZIP HOME PHONE	CITY, STATE ZIP HOME PHONE		
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN		
PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)		
ADDRESS	ADDRESS		
CITY, STATE ZIP	CITY, STATE ZIP		
WORK PHONE	WORK PHONE		
RESPONSIBLE PARTY INFORMATION (if Different than above)			
NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)		
CITY. STATE ZIP	CITY, STATE ZIP		
HOME PHONE	HOME PHONE		
RELATIONSHIP TO PATIENT			
PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY	POLICY#		
NAME OF INSURED	GROUP#		
ADDRESS OF INSURANCE COMPANY	COPAYAMT	\$	
CITY. STATE ZIP	DEDUCTIBLE	\$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE	
SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY	POLICY#		
NAME OF INSURED	GROUP#		
ADDRESS OF INSURANCE COMPANY	COPAYAMT	\$	
CITY, STATE ZIP	DEDUCTIBLE	\$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE	

I hereby authorize any insurance benefits to be paid directly to the physician providing services. I also authorize the physician to release any information necessary to process an insurance claim. I understand that I am responsible for all charges incurred with OB/GYN Associates that are considered as non-covered services by my insurance carrier. I also will be responsible for charges that result from failure to meet my insurance carriers requirements.

SIGNATURE OF PATIENT/GUARDIAN

DATE