UB|MD OBSTETRICS & GYNECOLOGY

Patient Information:

Name: ______________________________ Date of Birth:________________

Address: ____

Telephone: Home: ________________________ Cell:____________________________

Pharmacy: ____

Email: ____

Emergency Contact:

Name: ____________________	Name: ____________________
Telephone: ____________________	Telephone: ____________________
Relationship: ____________________	Relationship: ____________________

Insurance Information:

Insurance company: ____

Policy #: ________________________Group #:________________________

Name of Insurance holder: ____

Relationship to insurance holder (if not self): ____

DOB of Insurance holder (if not self): ____

I hereby authorize payment to UBMD Obstetrics-Gynecology for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and for all service rendered on my behalf or dependents.

I authorize the above physicians group to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of Responsible Party Date

Please provide the additional information below in order to complete the registration process with our practice. This information is used on our electronic health record (EMR) technology to monitor your health conditions, coordinate your treatment with national quality standards and communicate care decisions. Thank you.

Marital Status:
- Single
- Married
- Divorced
- Separated
- Widowed

Primary Language:
- English
- Other (Please specify) ____________________

Race:
- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White/Caucasian
- Unknown

Ethnicity:
- Hispanic or Latino
- Non-Hispanic or Latino
- Unknown

How did you hear about our practice?:
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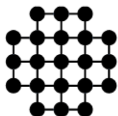
UB|MD  OBSTETRICS & GYNECOLOGY

HIPAA FORM

Name: ____

Date of Birth: ___________________________

Receipt of Notice of Privacy Practices

I, _________________________have received a copy of the UBMD Obstetrics-Gynecology, Notice of Privacy Practice.

Authorization to release information to family and/or friends

Name:	________________________	Name:	________________________
Relationship:	________________________	Relationship:	________________________
Phone #:	________________________	Phone #:	________________________

Authorization to leave messages (Check all that apply)

- ○ Home Answering Machine
- ○ Cell number
- ○ Work number _____________________
- ○ Mailing
- ○ Email

Restrictions to release of information

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____________________________________ __________________

Signature of Patient/Representative Date