PATIENT INFORMATION

LAST NAME:	FIRST NAME:	DATE OF BIRTH:
HOME PHONE:	CELL PHONE:	GENDER:
MAILING ADDRESS:	CITY, STATE, & ZIP CODE:	SSN:
EMAIL:	EMPLOYER:	WORK PHONE:
PREFERRED LANGUAGE:	ETHNICITY:	RACE:
PREFERRED PHARMACY:	PRIMARY CARE DOCTOR:	REFERRING DOCTOR:
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE:	RELATIONSHIP:

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME:	INSURANCE NAME:
MEMBER/SUBSCRIBER ID #:	MEMBER/SUBSCRIBER ID #:
GROUP NUMBER:	GROUP NUMBER:
POLICY HOLDER:	POLICY HOLDER:
POLICY HOLDER DATE OF BIRTH:	POLICY HOLDER DATE OF BIRTH:
POLICY HOLDER ADDRESS:	POLICY HOLDER ADDRESS:
RELATIONSHIP TO POLICY HOLDER:	RELATIONSHIP TO POLICY HOLDER:

CERTIFICATION AND AGREEMENT FOR RECORDS RELEASE AND PAYMENT

I hereby authorize Flagstaff OBGYN (FOG) to furnish information requested by insurance carriers concerning my healthcare. I authorize FOG to request and use my prescription medication history from other health care providers or third-party pharmacy benefit payers for treatment purposes. I assign FOG all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by insurance.

By signing below, I confirm I have received and agree to the terms of FOG's Financial Policy and Privacy Practices. I understand that no show/late cancellations are subject to a $25 fee and that reoccurring no shows/late cancellation may result in dismissal from practice. I understand payment is due at time of service/upon receipt of statement. I understand if my balance remains unpaid for more than 90 days my account may be turned over to collections, which may negatively impact my credit, and I may be responsible for additional collection fees. I understand accounts that have been turned over to collections will result in dismissal from the practice until full debt is paid.

Signature (Patient/Parent/Guardian/Guarantor) Today's Date