All American Ob/Gyn
413 Owen Drive Suite 101
Fayetteville, NC 28304
910-480-4880

PATIENT DEMOGRAPHIC SHEET

Primary Care Physician: ______________________________

Name: (Last, First, Middle): ______________________________

DOB: ______________________ Sex: F M

Address: ______________________________

City, State & Zip: ______________________________

Home Phone: ____________________

Cell Phone: ____________________ Work Phone: ____________________

Email: ______________________________

Marital Status: ____________________ Social Security #: ____________________

Employer Name: ______________________________

Employer Address: ______________________________

Employment Status: ____________________ Referred by: ____________________

Primary INS Name: ______________________________

ID #: ______________________ Plan #/Name: ____________________

Policy Holder Name: ______________________________

SPOUSE'S INFORMATION

Name :(Last, First, Middle) ______________________ Sex: M F

Address: (Inc City, State, Zip) ______________________________

Social Security #: ____________________ DOB: ____________________

Employment Status: ______________________________

Employer Name: ____________________ Work Phone: ____________________

Employer Address: ______________________________

EMERGENCY CONTACT

Name: ______________________________

Home Phone: ____________________ Other Phone: ____________________

Address:

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____

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ACKNOWLEDGMENT AND AUTHORITY FOR TREATMENT AND PAYMENT

_____ I hereby give All American OB/GYN consent to provide treatment thy may deem necessary to the patient above, and to release to my insurance carrier and its agents any information concerning my records needed to determine benefits payable for related services. I understand that I am responsible for charges incurred for services not covered y the insurance policy.

_____ I also acknowledge full responsibility for the payment of such services and agree to pay for them upon demand, in full, AT THE TIME OF SERVICE. If the physician must use a collection agency/attorney or court to collect its charges, then I will pay reasonable attorney fees and costs incurred in collecting same, regardless of insurance coverage.

______I hereby authorize payment directly to All American OB/GYN of the medical expense benefits otherwise payable to me but not to exceed my indebtedness to said physician on account of the enclosed charge.

Patient Name: ____

Patient Signature: ____

Parent/Guardian Signature: ________________________________ Date: ____________________________________