PRAIRIE POINT OBSTETRICS AND GYNECOLOGY

I authorize the following person(s) to have access to my medical and billing information and/or other purposes as I may direct._____
(Name) (Relationship)

PATIENT INFORMATION

Legal Name_____ Preferred Name_____

SSN_____ Date of Birth_____ Marital Status_____

Mailing Address_____
(Street) (City) (Zip code)

Home Phone _____ Cell Phone _____ Work Phone_____

Please leave a **Brief/Detailed** message on my **Home/Cell/Work** phone? (Circle preference)

Email address_____

Employer Name _____

Emergency Contact_____
(Name) (Phone number)

Preferred Pharmacy_____
(Name and Location)

Primary Care Physician_____

I hereby certify the information provided to Prairie Point Ob/Gyn to be true and correct.

Signature_____ Date_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber _____ Date of Birth_____

Subscriber Address (if different from Patient) _____

I authorize payment of insurance benefits to the physician/practice submitting claims on my behalf.

Signature_____ Date _____