Patient Information

Patients Name _____ Home #_____ Cell # _____
First Middle Initial Last

Date of Birth _____ Social Security Number _____ Marital Status: S M W D Sep

Address _____ City _____ State _____ Zip _____

Employer Name _____Work phone _____

Email_____

Spouse Name _____ Date of Birth _____Social Security _____

Release of Information/ Assignment of Insurance Benefits and Acknowledgements of Privacy Policy
This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all medical treatment which may be considered necessary or advisable. I authorize the **release of any information** necessary to obtain reimbursement for health care provided for all dates of service. I also authorize all payors to **make payments of all physicians benefits directly to Continental Divide OB/GYN** (Dr. Sironi). I understand that I am personally financially responsible to *Continental Divide OB/GYN* for all charges not covered by the assignment . In addition, I acknowledge that I have reviewed the copy of the **Notice of Privacy Practices** (in the white binders in lobby) for Continental Divide OB/GYN, and that I have the right to request restrictions as to how my health information may be used or disclosed and that Continental Divide OB/GYN is not required to agree to the restrictions that I may request.

Signature: _____ Date: _____

Emergency Contact/ Individuals who may receive health information- from Continental Divide OB/GYN, either in person or over the telephone. Thus may include appointment times, test results, patient progress and medications. This list will remain in effect for one (1) year or until I notify Continental Divide OB/GYN otherwise in writing.

Emergency Contact _____ Relationship _____ Phone _____

Those with whom your care may be discussed (1) _____ (2) _____

(3) _____ (4) _____ (5) _____