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San Jose, CA 95128-1600

CHART # ______________

DATE ______________

PATIENT NAME ______________________________ **Age** ________

BIRTHDATE Month _____ **Day** _____ **Year** _______ **SOCIAL SECURITY #** _____ – _____ – _____

Address ______________________ **Apt #** _____ **City** __________ **State** _____ **Zip** _______

Home Phone (   ) _____ – _______ Driver's License State & Number ______________

Cell Phone (   ) _____ – _______ Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Best Phone Number to Reach You: ( ) Home ( ) Work ( ) Cell

REFERRED BY ______________ IF NOT REFERRED, HOW DID YOU FIND US? ______________

Emergency Contact Name and Number ______________________ Relationship __________

PATIENT EMPLOYER ______________________ Occupation __________

Employer Address ______________________ City __________ State _____ Zip _______

Work Phone **(   )** _____ – _______ Extension _______ Hours? _______

SPOUSE NAME ______________ Social Security # _____ – _____ – _____ Birthdate __________

Spouse Employer ______________________ Occupation __________

Employer Address ______________________ City __________ State _____ Zip _______

INSURANCE: PRIMARY (SELF/SPOUSE/PARENT)

Insurance Name ______________________

Insured Name ______________________

INSURANCE: SECONDARY (SELF/SPOUSE/PARENT)

Insurance Name ______________________

Insured Name ______________________

Other Insurance Coverage (Circle One)? Yes No

I understand that by ***not*** supplying my ***complete or accurate insurance information,*** I shall be responsible for all account balances. In addition, I understand that I shall also be financially responsible for any failure to obtain prior authorization and/or any denial of prior authorization. **Please Initial Here** _______

ASSIGNMENTS, RELEASES, AND PATIENT RESPONSIBILITIES	Initial
• I understand that I am financially responsible for co-payments, deductibles, co-insurance percentages and for any services not covered by my health plan at the time of service	
• A service charge of 1.5% per month will be applied to unpaid balances over 30 days past due	
• I hereby authorize the release of any medical information required to process any claim	
• I hereby authorize my insurance benefits to be paid directly to Mama Baby Ob-Gyn Inc.	
• I hereby give permission to Mama Baby Ob-Gyn Inc. for my medical treatment, without any restriction	
• I acknowledge that I have received/seen a copy of this office's Notice of Privacy Practices	
• MISSED APPOINTMENTS: I agree to provide at least 24-hours notice if I cannot keep an appointment for any reason, failing which I shall be billed directly for and be responsible for paying a $50 fee	
• NON-EMERGENCY PAGING: If I page the physician for ANY REASON OTHER THAN A TRUE EMERGENCY, I shall be billed directly for and be responsible for paying a $50 fee	

Signed ______________________________ **Date** ______________