

Patient Demographic Form

Date _____

Patient Name: _____ Date of Birth: _____ SS#: _____

Address: _____ Apt# _____

City _____ State _____ Zip _____

Phone No 1: _____ Phone No 2: _____

Email: _____

Emergency Contact _____ Phone# _____

Insurance Company _____

Who is the primary subscriber on this insurance policy? _____ DOB: _____

Pharmacy Name: _____ Pharmacy No.: _____

Name of doctor who referred you to our practice: _____

I grant permission to Sweetwater OB GYN Associates to release information to the above insurance company upon request for the purpose of claims processing and payment. I also authorize insurance payment directly to the clinic for surgical and/or medical benefits for the services provided by Sweetwater OB GYN Associates. I understand that I am financially responsible for charges not covered by my insurance company.

Signature of Patient/Guardian

▶ × _____ **Date** _____

I voluntarily consent to medical care, treatment, and diagnostic tests that are believed to be necessary for me by my provider at Sweetwater OB GYN Associates, and his/her associates, assistants.

Signature of Patient/Guardian

▶ × _____ **Date** _____

I authorize Sweetwater OB/GYN Associates to email my Test results. Yes No

Signature of Patient/Guardian

▶ × _____ **Date** _____