

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.: _____
PCP Name:	_____ Referring Physician: _____

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** _____