PATIENT INFORMATION

LAST NAME:	FIRST NAME:	DATE OF BIRTH:
HOME PHONE:	CELL NUMBER:	GENDER:
MAILING ADDRESS:	CITY, STATE & ZIP CODE	SSN#:
EMAIL:	EMPLOYER:	WORK PHONE:
PREFERRED LANGUAGE:	ETHNICITY: (Please circle one)	RACE:
PREFERRED PHARMACY:	PRIMARY CARE DOCTOR:	REFERRING DOCTOR:
EMERGENCY CONTACT:	EMERGENCY CONTACT PHONE NUMBER:	RELATIONSHIP:

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME	INSURANCE NAME
MEMBER/SUBSCRIBER ID#	MEMBER/SUBSCRIBER ID#
GROUP NUMBER	GROUP NUMBER
POLICY HOLDER	POLICY HOLDER
POLICY HOLDER BIRTHDATE	POLICY HOLDER BIRTHDATE
POLICY HOLDER ADDRESS	POLICY HOLDER ADDRESS
RELATIONSHIP TO POLICY HOLDER	RELATIONSHIP TO POLICY HOLDER

CERTIFICATION AND AGREEMENT FOR RECORDS RELEASE AND PAYMENT

I hereby authorize Flagstaff OBGYN, LLC (FOG) to furnish information requested by insurance carriers concerning my illness. I hereby irrevocably assign to FOG all payments for medical services rendered. I understand that I am financially responsible for all charges, whether or not covered by insurance. I acknowledge that FOG participates in the AZ Health Information Exchange, Health Current and authorize any holder of medical information about me to release to FOG the information needed during the course of my treatment. By signing below**, *I have received and agree*** to the terms of FOG's **Financial Policy** and notice of **HIE participation** and **Privacy Practices**. I agree that Flagstaff OBGYN may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payers for treatment purposes.

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Signature (Patient/Parent/Guardian/Guarantor) Today's Date