

**NEW PATIENT INFORMATION**  
**(Please Print)**

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Home Phone # \_\_\_\_\_ Bus. Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Spouse/Guardian's Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse/Guardian's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

Insurance Information

Primary Insurance Company \_\_\_\_\_ HMO \_\_\_ PPO \_\_\_ Other \_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ HMO \_\_\_ PPO \_\_\_ Other \_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

Patient Authorization

**I hereby authorize Cool Springs OB GYN, P.C. to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits to include Medicare benefits directly to Cool Springs OB GYN, P.C. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I understand that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy shall be considered as valid as the original. I have read the above and fully understand the terms thereof.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date