Genesis Obstetrics & Gynecology
3075 Governor's Place Blvd Suite 210
Kettering, Ohio 45409
Phone (937) 293-5200 Fax (937) 424-5925
"Specializing in 3D/4D Ultrasound Imaging"
www.genesisobgynonline.com

Patient Information

Name:_____ Prev Last Name:_____
First MI Last

Address:_____ City:_____ State:_____

Zip:_____ **E-mail:**_____ Marital Status: M S W D DOB:_____ Age:_____

SSN:_____ Employer:_____

Home Phone: _(____)_____ Work Phone:_(_____)_____ Cell:_(_____)_____

Where Can We Leave Messages:_____Best Time to Call:_____

Emergency Contact:_____ Phone Number:_(_____)_____

Relationship to Patient:_____ Applicable POA/legal forms are required for legal guardians, POA, etc.

How did you hear about us: ___Internet ___Website ___Friend/Family ___Yellow Pages ___Yellow Book
___Christian Blue Pages ___ Physician (Name if applicable)_____
Other:_____

Insurance Information: A copy of your CURRENT Insurance Card must be produced at the time of service or you may be asked to reschedule your appointment. PENDING INSURANCE IS NOT ACCEPTED. We are billing your insurance carrier for you, we want to make sure you understand that the balance in full is your responsibility. If your insurance carrier has not paid in thirty (30) days, the balance will be turned to patient pay and payment is full will be expected. If you do not have active insurance coverage at the time the service is rendered, you may be responsible for full payment of the services you receive. All applicable copays are due BEFORE the service is provided. _____**Initials**

Primary Insurance:_____ **Please provide a copy of your card for our review.**

If you are not the subscriber please provide:
Insured's Name:_____ **Insured's DOB**_____ **Insured's SSN:**_____

Relationship to Patient: ____Spouse ____Parent ____Child ____Self ____Other_____

If Applicable:
Secondary Insurance:_____ **Please provide a copy of your card for our review.**

Insured's Name:_____ **Insured's DOB**_____ **Insured's SSN:**_____

Relationship to Patient: ____Spouse ____Parent ____Child ____Self ____Other_____

I have received a copy of Genesis OB/GYNs' privacy statement and HIPAA statement. _____**Initials**

I verify that the accuracy of the above information and authorize the release of any medical information necessary to process my claims. I request payment of my claims and where applicable, I authorize payment directly to the physician. A copy of this signature is as valid as the original.

_____ _____
Patient/Legal Representative Signature **Date**