MAGNOLIA OBSTETRICS AND GYNECOLOGY , PLLC

ERIN K. NEWMAN, MD LAUREN A. WELLS, MD CASEY E. ROTH, MD LINDSEY JACKSON, MD

DATE________________________ **ACCT#**________________ ***(OFFICE USE ONLY)***

LAST NAME________________ FIRST________________ MI______

STREET ADDRESS________________ APT#______

CITY________________ STATE______ ZIP CODE______

HM #________________ WK #________________ EXT______

CELL #________________ E-MAIL________________

EMPLOYER/BUSINESS NAME________________ OCCUPATION________________

AGE______ DOB_____/_____/_____ SS#_____-_____-_____ MARITAL STATUS______

SPOUSE LAST NAME________________ FIRST________________ MI______

FOR MEDICAL NECESSITY ONLY, WHAT IS YOUR RACE?________________

RESPONSIBLE PARTY, SPOUSE OR INSURED INFORMATION

LAST NAME________________ FIRST________________ MI______

AGE______ DOB_____/_____/_____ SS#_____-_____-_____ RELATIONSHIP______

EMPLOYER / BUSINESS NAME________________ OCCUPATION________________

WORK #________________ EXT______ CELL#________________

EMERGENCY CONTACT________________ WORK________________

RELATIONSHIP________________ CELL________________

HOW DID YOU HEAR ABOUT US?________________

PHARMACY NAME________________ PHONE #________________

INSURANCE (PRIMARY)________________ TEL #________________

CLAIMS ADDRESS________________

EMPLOYER NAME________________ GROUP #________________

EMPLOYEE NAME________________ DOB_____/_____/_____

SS# / ID#________________ REL TO PT________________

INSURANCE (SECONDARY)________________ TEL #________________

ID #________________ GROUP #________________

SIGNATURE________________ DATE________________

I UNDERSTAND AND AGREE THAT PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME OF SERVICE. ANY OTHER ARRANGEMENTS MUST BE MADE PRIOR TO SERVICE. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS TO THE CONTRACTED PROVIDERS WITH MAGNOLIA OBSTETRICS AND GYNECOLOGY ASSOCIATES, L.L.P FOR CHARGES WHICH MAY BE BILLED ON MY BEHALF. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY ACCOUNT. I UNDERSTAND THAT ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE AND THAT I MAY BE BILLED FOR ANY BALANCE REMAINING AFTER MY INSURANCE PROCESSES ANY AND ALL CLAIMS.