OBGYN
Specialists of Columbus

Ruthann F. Rees, M.D., Ph.D., FACOG

PATIENT INFORMATION **DATE: _____**

FIRST NAME: _____ MI: ____ MAIDEN NAME: _____

LAST NAME: _____ BIRTHDATE: _____ AGE: _____

SS#: _____ PHARMACY: _____

SINGLE MARRIED WIDOWED DIVORCED SEPARATED (please circle one)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME: _____

WORK: _____ EMAIL ADDRESS: _____

DRIVER'S LICENSE #: _____ PLACE OF EMPLOYMENT: _____

POSITION: _____ Full-time Part-time (please circle one)

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

CELL: _____ HOME: _____ WORK: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

RESPONSIBLE PARTY (NAME): _____ DOB: _____

SS#:_____CELL #:_____ HOME#: _____

RELATIONSHIP TO PATIENT: _____

2000 10th Avenue, Suite 380, Columbus, GA 31901
Phone: 706-324-0471 Fax: 706-324-0473
www.obgynsoc.com

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ADDRESS (IF DIFFERENT FROM ABOVE)
_____

EMPLOYER:_____

POSITION:_____

PRIMARY INSURANCE INS. COMPANY:
_____

MEMBER'S ID#:_____

GROUP#:_____ CO-PAY:$_____

NAME OF INSURED:_____

RELATIONSHIP: _____

INSURED'S DOB: _____

INSURED'S SS#:_____

SECONDARY INSURANCE INS. COMPANY:
_____

MEMBER'S ID#:_____

GROUP#:_____ CO-PAY:$_____

NAME OF INSURED: _____

RELATIONSHIP: _____

INSURED'S DOB: _____

INSURER'S SS#:_____

AUTHORIZATION, RELEASE & ACKNOWLEDGEMENT OF PAYMENT: I authorize the physician and other physicians or health-care professionals (interdisciplinary team members) to perform treatment and procedures necessary for proper care. I authorize OBGYN Specialists of Columbus to release any information (via mail, email or fax) including the diagnosis and records of any treatment or examination rendered to me/my child during the period of such medical care to third party payers, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to OBGYN Specialists of Columbus any benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the actual bill for services. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT WITHIN 60 DAYS OF SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS REGARDLESS OF INSURANCE STATUS. Finally, the HIPAA Notice of Privacy Practices has been made available to me and/or my dependant & I give consent for this office to discuss my treatment and financial responsibilities with the following people:

_____

Signature of Patient/Guardian: _____ Date: _____

Staff Signature: _____ Date: _____

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