

Glens Falls Obstetrics & Gynecology Center, P.C.

28 So. Western Ave.
Queensbury, NY 12804
(518) 798-6165
Fax (518) 798-0658

Douglas Provost, MD
Michael Guido, MD

Sereena Coombes, MD

Carrie Mylott, CNM
Marybeth Manrique, CNM

PATIENT INFORMATION

Date: _____ Date of Birth _____ Age: _____

Patient's Name _____ Marital Status: S M D W Sex: M F

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # & ext. _____

SS# _____ Occupation _____

Referring Physician _____ Primary Physician _____

Employer's Name: _____ Address: _____

Spouse's Name/Life Partner's Name: _____ Spouse's SS#: _____

In Case Of An Emergency, Contact: _____

If patient is a minor, PLEASE FILL IN THE FOLLOWING AND ABOVE:

Legal Guardian Name _____ Date of Birth _____

Relationship to Patient: _____ Guardian SS#: _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Message Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Employer: _____

Subscriber ID#: _____ Group #: _____ Co-pay Amount _____

Employee's Name: _____ Employee's DOB: _____

Secondary Insurance _____ Co-Pay Amount: _____

Subscriber ID#: _____ Group #: _____ Co-pay Amount _____

Employee's Name: _____ Employee's DOB: _____

Workman's Comp Carrier _____ Date of Injury _____

Carrier Address _____

Carrier Case # _____ WCB Case # _____ Carrier Phone # _____

No Fault Carrier _____ Accident Date _____

No Fault Carrier Address _____

Policy # _____ Claim # _____ Policy Holder _____

I authorize release of any information necessary to process my insurance claim, assign payments directly to my physician, and acknowledge that I am financially responsible for any unpaid balance. I assign all medical/surgical benefits to Glens Falls Obstetrics & Gynecology, PC.

Patient Signature _____ Date _____

Payment of Medicare Benefits: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to _____ for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Signature _____ Date _____

List all names of family, friends or others that we may discuss your PHI with (include those who may call on your bill)

Office Use Only:

HIPAA Consent Form Signed _____

Restrictions to PHI Disclosure Form Signed _____ Yes or No _____ (if yes attach copy

Verification of License _____ Initials

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PATIENT INFORMATION UPDATE

Patient Name _____

I authorize release of any information necessary to HCFA and/or my insurance company in order to process my insurance claim. I request assignment of benefits be paid directly to my physician, and acknowledge that I am financially responsible for any unpaid balance.

Signature _____ Date _____
(of parent/guardian if patient is under 21)

Primary Care Doctor: _____ Referring Doctor: _____

Update medical history from last visit, (new diseases, illnesses or problems), _____

Update family history _____

List any social/environmental changes since last visit _____

List any surgery since last visit _____

List current medications _____

New Insurance Information – Please show your card to receptionist.