NORTHWEST OB-GYN, INC: K.C. SANGHVI, M.D. DATE__________________

NAME____ MAIDEN________________
(LAST) (FIRST) (MIDDLE)
ADDRESS___________________________________CITY_____________STATE________ZIP____________

PHONE#: PRIMARY________________ SECONDARY___________________ WORK__________________
SS#__________________________DOB______________________MARITAL STATUS__________________
EMAIL: ____

EMPLOYER_____________________________OCCUPATION_______________________________________

FAMILY PHYSICIAN___________________________PHONE #_____________________________________
REFERRED BY: _______________________________RELATIONSHIP________________________________
PHARMACY NAME: ____________________ PHONE #____________________
ADDRESS: ____
OPTIONAL (THIS IS BEING ASKED BY GOVERNMENT ENTITIES AND WILL NOT IMPACT YOUR CARE WITH OUR PRACTICE.)
RACE: ______________PREFERRED LAUNGAGE_________________ETHNICITY: HISPANIC NON-HISPANIC

PRIMARY INSURANCE:

____

SUBSCRIBER'S NAME_____________________________SS#____________________DOB_____________________
SUBSCRIBER'S EMPLOYER___________________________________WORK #_____________________________
ID/POLICY#________________________GROUP#______________________EFFECTIVE DATE_________________
RELATIONSHIP TO PATIENT (PL. CIRCLE) SELF SPOUSE PARENT
OTHER________________________________

SECONDARY INSURANCE:

____

SUBSCRIBER'S NAME_____________________________SS#____________________DOB_____________________
SUBSCRIBER'S EMPLOYER___________________________________WORK #_____________________________
ID/POLICY#________________________GROUP#______________________EFFECTIVE DATE_________________
RELATIONSHIP TO PATIENT (PL. CIRCLE) SELF SPOUSE PARENT
OTHER________________________________

PLEASE READ CAREFULLY!

RELEASE OF PROTECTED HEALTH INFORMATION, PAYMENT OF SERVICES, AND CANCELLATION POLICIES: I authorized the use and disclosure of protected health information to carry out treatment, payment and health care operations. I authorize the assignment and payment of my insurance and government benefits to NORTHWEST OB-GYN, INC. and its physicians, assignees, and successors. I am responsible for the payment of any medical services that my insurance does not cover. I understand that I am also responsible for prompt payment of my deductible and co-insurance amounts. I understand that co-pays are to be paid in full at the time of my visit. If I am unable to pay at the time of service I may incur a $10 fee. I also understand that unpaid charges are subject to collection actions and will incur additional fees. It is my responsibility to notify Northwest OB-GYN, INC. if I am unable to keep my appointments. Failure to do so could result in additional fees and termination from the practice. It is also my responsibility to update any changes in the information provided above and compensate Northwest OB-GYN, INC. for any charges not collected because of my failure to do so.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:____