ATLAS OB-GYN

NEW PATIENT FORM

DATE: _____ PRIMARY LANGUAGE SPOKEN: _____

PATIENT NAME: _____
(Last) *(First)* *(Middle)*

CHECK ONE: SEX: M_____ F_____ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____
RACE: _____ ETHNICITY: _____ ADVANCED DIRECTIVES: YES ____ NO ____
DATE OF BIRTH: _____ SOCIAL SECURITY #:_____
RESPONSIBLE PARTY:_____RELATIONSHIP:_____
ADDRESS: _____
(Street) *(City)* *(Zip code)*

HOME TELEPHONE #: (_____) _____ CELL TELEPHONE #: (_____) _____

EMAIL: _____

EMPLOYED BY: _____ OCCUPATION: _____

WORK # (_____) _____ BUSINESS ADDRESS:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____)_____

PRIMARY PHARMACY: _____ PHONE #: (____)_____ LOCATION: _____

REFERRED BY:_____

REASON FOR VISIT: _____--_____

CHECK ONE: *ILLNESS/INJURY RELATED TO*: WORK ____ AUTO ____ OTHER ____

DATE OF INCIDENT: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY: _____
POLICY/ID#_____ GROUP #_____
POLICY HOLDER:_____ RELATIONSHIP:_____
POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____
NAME OF SECONDARY INSURANCE COMPANY: _____
POLICY/ID#_____ GROUP #_____
POLICY HOLDER:_____ RELATIONSHIP:_____
POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO ATLAS OB-GYN & CONSENT FOR TREATMENT

I hereby authorize Atlas OB-GYN and its employees and agents to release my medical records documenting my examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Atlas OB-GYN for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I agree to be financially responsible to Atlas OB-GYN for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Atlas OB-GYN files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out of pocket costs" are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment accepted include check, cash and credit card.

I further agree to pay all costs of collection, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Texas.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Atlas OB-GYN physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

DATE: _____

PLEASE PRINT PATIENT'S FULL NAME: _____

PATIENT'S SIGNATURE: _____

WITNESS'S SIGNATURE: _____