Annual Patient Registration

Name: First M. Last ______ Date of Birth ______ Age ______ Marital Status ______ SSN (optional) ______

Address: Street ______ City ______ State ______ Zip ______

Patient Employer ______ Home Phone ______ Work Phone ______ Cell Phone ______

Where would you like us to reach you? ______ OK to leave a detailed message? ______

Primary Insurance ______ Policy Holder ______ Relationship to Patient ______

Policy Holder's Employer ______ Work Phone ______ SSN (optional) ______ Date of Birth ______

Policy Holder's Employer's Address ______ City ______ State ______ Zip ______

Secondary Insurance ______ Policy Holder ______ Relationship to Patient ______

Policy Holder's Employer ______ Work Phone ______ SSN (optional) ______ Date of Birth ______

Policy Holder's Employer's Address ______ City ______ State ______ Zip ______

If you would like someone other than yourself and your Physician to access your medical information, list here: ______

Patient Contract

Greenbriar Ob/Gyn, P.C. will file medical claims to contracted insurance companies *when provided with correct and current information.* If the patient does not have the Policy Holder's Information requested above or does not present a valid insurance card at the time of service, the Patient must pay the entire amount at time of service.

Greenbriar Ob/Gyn, P.C. is not responsible for determining the amount of the co-pay, deductible, or other amounts designated by the insurance company as the responsibility of the Patient of the Policy Holder. Co-Payment is due at the time of service.

Guarantor accepts responsibility for any and all charges for medical treatment rendered by Greenbriar Ob/Gyn, P.C.

Patient authorizes Greenbriar Ob/Gyn, P.C. to release information concerning her health and treatment to the contracted insurance company. Patient authorizes the insurance company to release to Greenbriar Ob/Gyn, P.C. any information pertinent to her care, benefits, and precertification. The undersigned assigns to Greenbriar Ob/Gyn, P.C. all payments for medical services rendered. The undersigned authorizes Greenbriar Ob/Gyn, P.C. to contact me by mail or by phone regarding billing statements and appointment reminders.

All information given above is correct to the best of my knowledge.

______ Patient Signature Date ______ Guarantor Signature Date