LINCOLN CENTER
OBSTETRICS & GYNECOLOGY

Chart Number: ____________________

Lincoln Center Physician: ____________________

PATIENT INFORMATION (please notify our office of any changes in the following information)

Name: ____________________ ____________________ ____________________ ____________________
Last First Middle Suffix

Address: ____
(IF PO BOX, **WE MUST ALSO HAVE HOUSE ADDRESS**)

City / State / Zip: ____________________ / ____________________ / ____________________

Social Security Number | Date of Birth | Marital Status | Primary Care Physician

Home Phone | Work Phone, Extension | Cell Phone | Referring Physician

Email Address | Employer | Occupation

Preferred Language

Name of Parent, Spouse, Nearest Friend or Relative

How Related

ETHNICITY:

____ **Hispanic or Latino**
____ **Not Hispanic or Latino**
____ **Decline to Answer**

RACE:

____ **American Indian or Alaska Native**
____ **Asian**
____ **Black or African American**
____ **Native Hawaiian or Other Pacific Islander**
____ **White**
____ **Decline to Answer**

Their Home Phone | Their Work Phone, Extension | Their Cell Phone

IF INSURANCE REQUIRES A REFERRAL, PLEASE HAVE IT WITH YOU OR HAVE IT MAILED TO US

Health Insurance Company (Primary) | Effective Date | Policy ID Number | Group Number

Name Policy is Under | Their Date of Birth | Their Employer | Their Sex

Health Insurance Company (Secondary) | Effective Date | Policy ID Number | Group Number

Name Policy is Under | Their Date of Birth | Their Employer | Their Sex

OFFICE CREDIT POLICIES:

Payment is requested when service is rendered. OB patients without insurance must have their estimated fee paid in full by delivery date. I hereby assign benefits from Medicare/Medigap/Medicaid/my health insurance(s) to the Lincoln Center physicians, Trobough, Gleason, Dickson, Teply, Morrison and Brey for all services billed to Medicare/Medigap/Medicaid/my health insurance company(s) for which I have not paid in full. A copy of this assignment shall be as valid as an original. I understand I will be financially responsible for any services considered to be non-covered by Medicare/Medigap/Medicaid/my health insurance company(s). If my account is turned over to a collection agency, I understand that I may be subject to interest charges. I authorize the release of any medical information necessary to process my claims, and for Utilization Review/Chart Audits that may be required under the guidelines of Medicare/Medigap/Medicaid/my health insurance company(s). It is understood and agreed that the physicians of Lincoln Center OB/GYN, PA have the right to designate which practitioner(s) will perform medical services requested by the undersigned patient.

DATED ____________________ **SIGNED:** ____________________