Ob-Gyn Physicians, Inc.

A Division of Mid-Atlantic Women's Care, P.L.C.
J. Floyd Clingenpeel, MD
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WELCOME TO OUR OFFICE!

Patient Information

Please Print Clearly

Name: _____
First M.I. Last

Address: _____

_____

City: _____St: _____ Zip: _____

SSN: _____

Date of Birth: _____ Age: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Occupation: _____

Work Phone: _____

Spouse or Parent's Info:

(PLEASE CIRCLE ONE)

Name: _____

SSN: _____

Employer: _____

Occupation: _____

Work Phone: _____

Emergency Contact

(Not Living With You)

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

FIRST INSURANCE INFORMATION:

MUST ATTACH CARD

Policyholder Name: _____

Policyholder Birth Date: _____

Relationship:_____

SECOND INSURANCE INFORMATION:

SEE ATTACHED CARD

Policyholder Name: _____

Policyholder Birth Date: _____

Relationship: _____

I hereby affirm the information above is accurate and do authorize treatment of the above named patient today and on all subsequent visits. I, the undersigned patient or guarantor, agree to be responsible for payment of treatment charges and I understand that insurance coverage does not relieve me of this responsibility. I will also be responsible for any and all reasonable costs of collection, attorney fees, and court costs incurred in the collection of any amount due to OB/GYN PHYSICIANS. I further agree to the release of all information obtained by OB/GYN PHYSICIANS to insurance companies or their representatives concerning the above named patient and assign all benefits from said insurance company to OB/GYN PHYSICIANS, INC.

Virginia law authorizes health care providers to test patients for HIV, Hepatitis B and Hepatitis C Antibodies when a health care provider is exposed to the blood or other body fluids of a patient in a manner which may transmit these viruses. In the event of such an exposure, you will be deemed to have consented to such testing and release of test results to the health care provider who was exposed. You will be informed before your blood is tested and given the results of the tests. Positive tests are required to be reported to the Virginia Department of Health.

I am acknowledging that a copy of Mid-Atlantic Women's Care Privacy Notice has been made available to me pursuant to the Federal regulations known as the HIPAA rule.

SIGNATURE:_____
DATE:_____

SIGNATURE:_____
DATE:_____

SIGNATURE:_____
DATE:_____