



**OB/GYN SPECIALISTS OF NORTHERN KENTUCKY
PATIENT REGISTRATION FORM**

Name _____
Last First Middle Initial (Maiden If Married)

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Birth Date _____ Soc Sec # _____ Cell Phone # _____

Marital Status: Single Married Divorced Widowed Student: Full Time Part Time

Employer _____ Occupation _____

SPOUSE or RESPONSIBLE PARTY: Name _____

Relationship to Patient _____ Spouse _____ Parent _____ Other _____ Soc Sec # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Birth Date _____

Employer _____ Occupation _____

PRIMARY INSURANCE:

Subscriber's Name for 1st Ins _____ Effective Date _____

Relationship of Subscriber to Patient _____ Self _____ Spouse _____ Parent _____ Other _____ Birth Date _____

1st Ins Co Name _____ ID/Policy # _____

1st Ins Co Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE:

Subscriber's Name for 2nd Ins _____ Effective Date _____

Relationship of Subscriber to Patient _____ Self _____ Spouse _____ Parent _____ Other _____ Birth Date _____

2nd Ins Co Name _____ ID/Policy # _____

2nd Ins Co Address _____ City _____ State _____ Zip _____

Family Physician _____ Is this visit for pregnancy? _____yes _____no

Person to contact in case of emergency _____

Relationship to you _____ Phone # _____

RELEASE OF PROTECTED HEALTH INFORMATION AND PAYMENT FOR SERVICES: I authorize the use and disclosure of protected health information and other demographic information to carry out treatment, payment, and health care operations. Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures. I authorize the assignment and payment of my insurance benefits to the physicians of OB/GYN Specialists of Northern Kentucky, to include government benefits. If my insurance plan does not cover the (specialty) medical services or does not pay for certain services or goods as benefits, I agree that I am financially responsible. Also, I understand that I am responsible for the annual deductible, co-insurance amounts, and office visit co-pay fees per my insurance contract.

Patient's or Authorized Person's Signature: _____

Date: _____