☐NEW PATIENT ☐UPDATE

Date_____
ACCT #_____ (PLEASE PRINT)

Patient's Name (Last) (First) (MI)	S.S.# / Maiden Name	Marital Status S M W D	Date of Birth MO/ DAY/YEAR	Age
Street Address	City, State, Zip		Patient Home Phone # ( ) -	
Patient's Employer (Parent's Employer if Responsible)		Occupation	Patient Cell Phone # ( ) -	
Employer's Address	City, State, Zip		Patient Work Phone # ( ) -	
Please Circle Which Contact Number You Wish to Receive Reminders By HOME CELL		Email Address		
Emergency Contact Name		Relationship to Patient	Emergency Contact Phone # ( ) -	
Primary Care Physician's Name	Physician Phone # ( ) -		Religious Preference	

Consent to Communicate

I hereby give Saint Louis Associates in OB/GYN, Inc my permission to contact me or leave messages on the following (choose those that apply):

Home ( )_____-_____ Cell ( )_____-_____ Other ( )_____-_____

I hereby give Saint Louis Associates in OB/GYN, Inc my permission to release any or all of my health information to the following person(s). I will not hold Saint Louis Associates in OB/GYN, Inc liable for any information released.

_____(_____)_____-_____
Name of Person to Release Information to (PLEASE PRINT) Relationship to Patient Contact Number

_____(_____)_____-_____
Name of Person to Release Information to (PLEASE PRINT) Relationship to Patient Contact Number

_____(_____)_____-_____
Name of Person to Release Information to (PLEASE PRINT) Relationship to Patient Contact Number

_____ _____/_____/_____
SIGNATURE OF PATIENT Date mm/dd/yyyy

Primary Insurance Name		Secondary Insurance Name	
Member ID Number		Member ID Number	
Group Number	Effective Date	Group Number	Effective Date
Subscriber Name	Relationship to Patient	Subscriber Name	Relationship to Patient
Subscriber Date of Birth MO/ DAY/YEAR	Subscriber S.S. #	Subscriber Date of Birth MO/ DAY/YEAR	Subscriber S.S. #

FINANCIAL POLICY

Please verify you insurance coverage and bring your current insurance card with you at the time of each visit. It is the responsibility of the patient to know your insurance coverage. It is also the responsibility of the patient to obtain a referral if one is needed. If a patient does not provide the necessary referral or authorization the financial responsibility becomes that of the patient's. At each visit, full payment is due, unless you are enrolled in a health care plan in which Saint Louis Associates in OB/GYN, Inc is also a participant. The following are accepted forms of payment for services provided: Visa, MasterCard, Discover, debit cards, checks, and cash. All payments are to be made prior to your scheduled visit to the receptionist. Do to our Providers being specialists; your insurance may require co-payments for each office visit. If a patient is to pay in excess of their due balance, no credits will be issued to the patient's account until all claims have been adjudicated and have been fully processed through the patient's health care plan. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.

SIGNED (Patient or Guardian)_____ DATE _____