WGM
Obstetrics &
Gynecology P.C

How do you wish to be called? By your First name Mrs. Ms.

Today's Date_____
Patient Name_____
Address_____
City, State, Zip_____
Date of Birth_____
Social Security #_____
Telephone#_____
Cell Phone#_____
Employer_____
Work Phone#_____

Marital Status S M D W
Language Spoken_____
Spouse's Name_____
Name of person to be called in an emergency_____
Relationship_____
Phone#_____
Family Dr._____
Referred by_____
Email_____

PRIMARY INSURANCE

Insurance Company_____
Address_____
City, State, Zip_____
Phone#_____
Insurance ID#_____
Insurance Group Name_____

Policy Holder_____
Policy Holder's SS#_____
Policy Holder's DOB:_____
Relationship:_____
Policy Holder's Employer_____
Insurance Group #_____

SECONDARY INSURANCE

Insurance Company_____
Address_____
City, State, Zip_____
Phone#_____
Insurance ID#_____
Insurance Group Name_____

Policy Holder_____
Policy Holder's SS#_____
Policy Holder's DOB:_____
Relationship:_____
Policy Holder's Employer_____
Insurance Group #_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO WGM OBSTETRICS & GYNECOLOGY, PC. I AUTHORIZE WGM OBSTETRICS & GYNECOLOGY,PC TO SUBMIT CLAIMS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON EACH AND EVERY CLAIM SUBMITTED. I UNDERSTAND THAT CERTAIN CHARGES MAY NOT BE COVERED BY MY MEDICAL INSURANCE, AND I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES. I AGREE THAT IN THE EVENT MY ACCOUNT IS PLACED IN COLLECTIONS, THERE WILL BE A 30% SURCHARGE INCURRED ON THE BALANCE DUE.

SIGNED_____DATE_____