

NORTHLAND OB-GYN ASSOCIATES P.A.

- STEFAN P. GUTTORSSON
- JAMES A. SEBASTIAN
- ANN M. ROCK
- SUSAN M. GOLTZ
- ELISABETH A. REVOIR
- JUDITH L. JOHNSON
- MELISSA R. STANK
- JENNIFER R. BOYLE
- Nurse Practitioner

PLEASE PRINT

Date _____ REFERRED BY: _____ FRIENDS / RELATIVES/ ETC. YELLOW PAGES

NAME OF PHYSICIAN _____

Social Security #: _____ Patient's full name: _____
Last First Middle

Address: _____ County: _____

Zip Code: _____ State: _____ City: _____ Home phone: _____ Work phone: _____

Birth date: _____
Month Day Year

Patient employer: _____ Occupation: _____

Address: _____
City State Zip

DO YOU HAVE ANY KNOWN ALLERGIES? _____

If married, your spouse's full name: _____
Last First Middle Date of Birth

Employer: _____ Occupation: _____

Work phone: _____ Address: _____

Spouse's Social Security #: _____

Person to contact in case of emergency: _____ Phone: _____
Relationship to Patient (Father, Mother, Uncle, etc.)

This Section ALWAYS Needs to Be Completely Filled Out

COMPLETE NAME OF PRIMARY INSURANCE COMPANY: _____

Address where claims are to be mailed: _____

Insurance company phone #: _____ Precertification phone # (if applicable): _____

Subscriber (Name policy is under): _____ Relationship to Patient: Self Child Spouse Other _____ Birth Date: _____

Contact, ID, or subscriber number: _____ Group number: _____ If HMO, Primary Physician: _____

COMPLETE NAME OF SECONDARY INSURANCE COMPANY (If applicable): _____

Address where claims are to be mailed: _____

Insurance company phone #: _____ Precertification phone # (if applicable): _____

Subscriber (Name policy is under): _____ Relationship to Patient: Self Child Spouse Other _____ Birth Date: _____

Contact, ID, or subscriber number: _____ Group number: _____ If HMO, Primary Physician: _____

MEDICARE:

Number: _____

COUNTY MEDICAL ASSISTANCE:

Number: _____

ASSIGNMENT OF BENEFITS:

I hereby authorize that payment due me in my pending insurance claim be made directly to NORTHLAND OB-GYN ASSOCIATES, P.A. Payment is authorized upon receipt of an itemized statement.

I authorize the release of any medical information necessary to process any insurance claim.

I authorize the release of any medical information to my referring MD, or referred to MD.

I understand that I am responsible for all claims incurred regardless of any insurance coverage.

Signed: _____

Dated: _____