WELCOME TO BORUCH MIDWIFERY P.C.

Thank you for selecting our practice for OB/GYN needs! We will strive to provide you with the best possible healthcare. To help us meet your OB/GYN healthcare requests, please fill out this form completely in ink and bring it to your first appointment.

Name (as it appears on your insurance card)

Last: _____ First: _____Middle: _____

Maiden name (if applicable): _____Birthdate:___/_____/_____

Social Security #: _____Marital Status: [ ] Single [ ] Married [ ] Other _____
Address: Street)_____Apartment #: _____
(City) _____ (State) _____ (Zip) _____
Home #: (_____) _____Cell #: (_____)_____
Work #: (_____) _____ Ext _____E-mail: _____
Occupation: _____ Employer: _____
Employer's address: _____Phone #: _____
Emergency contact: _____ Phone #: _____
Primary Care Physician: _____Phone #: _____

SPOUSE'S INFORMATION [ ] **No spouse**

Name: Last: _____First: _____Middle: _____
Birthdate: ___/____/_____ Social Security #: _____
Employer & Address: _____
Work #: (_____) _____ Ext _____ : Cell #: (_____) _____

RESPONSIBLE PARTY **[ ] Self [ ] Spouse**

Name: Last: _____ First: _____Middle: _____
Birthdate: ___/____/_____Social Security #:_____
Address: _____
Home #: (_____) _____Cell #: (_____)_____
Work #: (_____) _____Ext ____E-mail: _____
Employer & Address:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to BORUCH MIDWIFERY, P.C. when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize BORUCH MIDWIFERY, P.C. to use or disclose any information for treatment, payment and health care operations. I authorize that the physician/midwieves and/or employees of BORUCH MDWIFERY, P.C. can contact me via all electronic formats (such as telephone, e-mail, fax, etc) or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice of Privacy Practices.

Patient's signature: _____Date: _____
Guardian's Signature: _____ Date: _____
Guardian's relationship: _____

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INSURANCE INFORMATION

Please provide information on ALL MEDICAL INSURANCE POLICIES you are covered under.

Primary Insurance Information

Insurance Carrier: _____
Identification #: _____Group #: _____
Insurance Claims Address: _____
Insurance Telephone #: _____
Subscriber Name: _____
Subscriber's Social security #: _____Date of Birth: _____
Relationship to patient:[ ]Self [ ]Spouse [ ]Mother [ ]Father [ ]Domestic Partner[ ]Other
Subscribers Address: _____

Secondary Insurance Information

Insurance Carrier: _____
Identification #: _____Group #: _____
Insurance Claims Address: _____
Insurance Telephone #: _____
Subscriber Name: _____
Subscriber's Social security #: _____Date of Birth: _____
Relationship to patient:[ ]Self [ ]Spouse [ ]Mother [ ]Father [ ]Domestic Partner[ ]Other
Subscribers Address: _____

I agree and understand that:

- Failure to complete and give accurate information may result in a delay or a denial of payable benefits and may cause unexpected expenses to me. BORUCH MIDWIFERY PC will not re-file a claim 30 days from the date of service;
- Knowingly or intentionally providing false insurance information may be deemed insurance fraud.
- If my insurance does not make payment within 45 days, I will be responsible to pay the balance in full;
- Regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered as per the financial policy;

I authorize:

- Payment to BORUCH MIDWIFERY PC when assignment has been taken;
- BORUCH MIDWIFERY PC to initiate a complaint or appeal to my insurance carrier or to the Insurance Commissioner of New York State or other states, if appropriate;
- BORUCH MIDWIFERY, P.C. to use or disclose any information for treatment, payment and health care operations.

I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I have read or received a copy of the Notice of Privacy Practices. I certify that the above information is correct and understand that I am obligated to provide this information.

Patient Name (Print): _____DOB: _____
Patients Signature: _____
Guardian/Responsible Party Name (Print) _____
Guardian/Responsible Party signature: _____
Relationship to Patient: _____