Biltmore
OB-GYN, P. A.

Name_____ **SS #**_____ **Birthdate**_____ **Age**_____

Marital Status
☐ Single ☐ Married ☐ Partnered
☐ Separated ☐ Divorced ☐ Widowed

Race
☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other ☐ Unknown ☐ Declined

Ethnicity
☐ Unknown ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Preferred Language
☐ English ☐ Spanish ☐ Other _____

Home Address_____ **City/State**_____ **Zip**_____

Mailing Address_____ **City/State**_____ **Zip**_____

Home Phone _____ **Cell Phone** _____ **Reminder calls: ☐ Home ☐ Cell**

Email _____ **Preferred Communication ☐ Phone ☐ Email ☐ Mail**

Patient's Employer_____ **Occupation/Student**_____ **Business Phone**_____

Family Doctor _____ **Other Specialist**_____

Preferred Pharmacy_____ **Mail Order Pharmacy**_____

Emergency Contact Person _____ **Home Phone**_____ **Cell/Other** _____

Spouse/Parent /Associated Party Name _____ **Birthdate** _____ **SS#**_____

Address (if different from patient) _____ **City, State, Zip** _____

Employer _____ **Business Phone** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I authorize payment of Medicare/other insurance company benefits be made on my behalf to Biltmore OB GYN, PA for any services furnished me by that health care practice. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that it is required to notify the health care provider of any other party who may be responsible for paying for my treatment.

Patient Signature_____ **Date Signed**_____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I have received or been given the opportunity to review the notice of privacy practices for Biltmore OB GYN, PA.

Patient Signature_____ **Date Signed**_____

AUTHORIZATION FOR e-PRESCRIBE AND RETRIEVAL OF PRESCRIPTION HISTORY

I understand that Biltmore Ob-Gyn uses electronic prescribing. Prescriptions will be sent and medication history may be obtained electronically.

Patient Signature_____ **Date Signed**_____