NEW BEGINNINGS OB/GYN, PA
336 N. BABCOCK ST. STE 101
MELBOURNE, FL 32935
PHONE (321)775-1470
FAX (321)775-1480

DEMOGRAPHICS

Name: _____ Date of Birth: ____/____/____AGE:____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____ Cellular Phone :( ) _____
Social Security Number: _____
E-mail: _____ Marital Status: __Single __Married __Divorced __Widowed
Smoker:____YES_____NO Alcohol:___NO____YES
Employer: _____ Occupation: _____
Work Phone: _____ Extension: _____
Spouse/significant other: _____ Phone :( ) _____
Emergency contact: _____ Phone :( ) _____
Referred to practice by: _____
Primary Care Provider: _____ Phone :( ) _____ Fax :( ) _____
Pharmacy: _____ Phone :( ) _____
Primary Language Spoken: _____ DO you have a living will? _____

INSURANCE INFORMATION

Primary: _____
ID#: _____
Group#: _____
Claims Address: _____
_____
Subscriber: Spouse Self Dependent
Name of subscriber: _____
Subscriber's SSN/ DOB: _____

Secondary _____
ID#: _____
Group #: _____
Claims Address: _____
_____
Subscriber: Spouse Self Dependent
Name of subscriber: _____
Subscriber's SSN/DOB: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICAIN: I hereby authorize payment directly to the physician for the surgical and/or medical benefits, if any, otherwise payable to me for her services as described. Realizing I am responsible to pay non covered services. If I have more than one insurance and I do not disclose that information I am responsible for payment of all rendered services.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize New Beginnings OB/GYN to release information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE: _____ **DATE:** _____