Sweetwater Ob/Gyn Associates

Patient Demographic Information

Name (Nombre)	Date of Birth (Fecha de Nacimiento)
Address (Direccion) Apt#	Social Security # (No. de Seguro Social)
City, State, Zip (Ciudad, Estado, Codigo Postal)	Home Phone (Numero de Telefono)
Marital Status (Estado Matrimonial)	Cell Phone (Otro Numero de Telefono)
Driver's License # (No de Licencia)	Occupation (Ocupacion)
Emergency Contact (Contacto de Emergencia)	Employer Name (Nombre de su Empleador)
Relationship (Relacion)	Address, City, State, Zip (Direccion, Ciudad, Estado, Codigo Postal)
Contact Phone (Numero de Telefono)	Work Phone (Numero de Telefono de su Trabajo)

Insurance Company (1) Medicare/Medicaid (Primer Compania de Seguro Medico)	Member Name (Nombre del Miembro)	Employer (Empleador)
If you have Medicare, Is Medicare your: (Es Medicare Primer/Secundaria)	Member Date of Birth (Miembro Fecha de nacimiento)	Member SS# Miembro # Seguro Social)
Policy# or Cert.# or I.D.# or Reciepient #	Group# (Grupo#) or Case#	Effective Date (Dia Effectivo)

Insurance Claim Mailing Address (Direccion de Correo)	City (Ciudad)	State (Estado)	Zip (Codigo Postal)	Insurance Phone# (Telefono)

Insurance Company (2) Medicare/Medicaid (Primer Compania de Seguro Medico)	Member Name (Nombre del Miembro)	Employer (Empleador)
Policy# or Cert.# or I.D.# or Reciepient # (Secondary)	Member Date of Birth (Miembro Fecha de nacimiento)	Member SS# Miembro # Seguro Social)
Group# (Grupo#) or Case# (Secondary)	Effective Date (Dia Effectivo)	

Insurance Claim Mailing Address (Direccion de Correo)	City (Ciudad)	State (Estado)	Zip (Codigo Postal)	Insurance Phone# (Telefono)

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 unless other arrangements have been made.

Insurance Authorization and Assignment:

I hereby authorize any physician who has treated or attended me or my dependent to furnish information concerning my illness and treatments and I herby assign to the physician(s) all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I know that I have a right to receive a copy of the authorization. I agree a photographic copy is a valid as the original.

Signature:_____ Date:_____

Authorizacion Para Solicitar Informacion Y Paga De Beneficios

Doy permiso a cualquier medico que me a tratado a mi y a mis depedientes proveir cualquier informacion medica solicitada. Una copia de esta autorizacion estrara considerado effectivo y valuado como original.