OBGYNASSOCIATES

OB-GYN Associates P.C.
45 East 85th Street, New York, NY 10028

INSURANCE INFORMATION

Date ______________________________

Name ____Age __________DOB ___________________

Social Security# _______________________Marital Status (M) ___(S) ___(W) ___(SEP) ___(D) ___

Address ____ Apt. ___________

City ____ State _________________ Zip ______________

Home Phone (______) _______________________ Cell Phone (______) _______________________

E-mail ____

Employer ________________________________ Business Phone (____) ________________ Ext ____

Emergency Contact Phone Number *REQUIRED* (______) ________________________________

Spouse Name ____________________________________ Age __________DOB ___________________

Social Security # ____________________________ Business Phone (____) ________________ Ext ____

Employer ____

YOUR PRIMARY INSURANCE CO ____

Address ____

ID # on card _____________________________________ Group # _____________________________

Telephone # on card (______) _____________________ Co-Pay $______________________________

Are you covered by your employer? Yes No Policyholder: Self Spouse Parent

If your parent is the policyholder, please provide the following information:

Parent's Name ____ DOB _______________________

Phone (______) ______________________ Social Security# __________________________________

Employer ____

***The receptionist will request a copy of your insurance card so that lab work and/or Pap smear may be sent to a lab that participates with your insurance plan (if possible).**

SECONDARY INSURANCE INFORMATION: This pertains to an additional policy that takes over from the primary or (original policy) OR if your spouse has additional insurance that you are covered under OR if you have a Hospital Policy that is different from your physician coverage (e.g. GHI and Blue Cross, any indemnity plan, Guardian, Prudential etc. and Blue Cross for hospital.)

Policyholder: Self ____ Spouse ____ Parent ____
Name of Insurance Co ____
Address ____
ID # on card _____________________________________ Group # _____________________________
Telephone # on card (______) _____________________ Co-Pay $______________________________

PLEASE NOTE: Payment is expected at the time of your visit. If you are in a plan that our office participates with, your co pay is paid at the time of your visit. If you do not have verification of your coverage with one of our plans, you will be charged our regular visit fee until this has been verified.

Signature: ________________________________ ________________________________

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