Parkside OBGYN & Medical Spa

Today's Date_____

Patient Name:

Name (Legal) Last_____ First_____ M.I._____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell/Pager_____

E-Mail_____* Date of Birth_____ Age_____ Social Security #_____

Occupation_____ Employer_____

Spouse_____ Employer_____ Work Phone_____

Relationship to Responsible Party _____Self _____Spouse _____Son _____Daughter _____Other

Responsible Party: (Person who should receive the bill)

Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Social Security #_____

Date of Birth_____ Age_____ Employer_____

Referred By:_____

Insurance: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance_____

ID/Policy #_____ Suffix_____

Group #_____

Claims Address_____

Claims Phone_____

Name of Policy Holder_____

Date of Birth_____

Phone #_____

Employer_____

Secondary Insurance_____

ID Policy #_____ Suffix_____

Group #_____

Claims Address_____

Claims Phone_____

Name of Policy Holder_____

Date of Birth_____

Phone #_____

Employer_____

Notify In Emergency:

Name_____ Relationship_____ Phone_____

Consent for test results: I give Parkside Ob/Gyn permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)

____Voice mail at work _____Answering machine at home _____Other _____ Do not leave a message

* I further consent Parkside Ob/Gyn and Medical Spa to provide communications and/or lab results through my e-mail_____(initial)

Patient and/or Insured Authorization

I hereby authorize my insurance companies to make payment directly to Beth Roland M.D., P.C., its trade names, or its Billing Company. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance company including the costs of collection, collection fees, and attorney fees. Unpaid balances will be charged 1.5% interest per month. I authorize the release of any medical information necessary to process these claims. **A $30.00 fee will be charged for any appointment that has not been cancelled 48 hours in advance or a "No Show".** Thank you for your cooperation.

Patient Signature:_____ Date:_____