

APPLICATION FOR OB CARE - Dr. Crowell

Have you been seen previously by: ____ Dr. Brummer ____ Dr. Bingham ____ Dr. Heischmidt ____ Dr. Crowell
Family Physician: _____ Referred by: _____
Last Menstrual Period: _____
Is this your first pregnancy? Yes No Number of Previous Pregnancies: _____
Type of delivery? ____ Vaginal ____ C Section Any complications during pregnancy? _____

Patient's Full Name: _____ Age: _____ DOB: _____
Previous/Maiden Name: _____
Address: _____ City: _____ St. _____ Zip: _____
Home Phone: _____ Married Single Divorced Separated Widowed
Social Security No.: _____ Driver's License No.: _____
Patient's Employer: _____ Work No.: _____ Ext.: _____
Address: _____ City: _____ St. _____ Zip: _____
Occupation: _____

Spouse/Guardian: _____ DOB: _____ Social Security No.: _____
Spouse's/Guardian's Employer: _____ Work No.: _____ Ext.: _____
Address: _____ City: _____ St. _____ Zip: _____
Occupation: _____

In case of emergency, contact (other than spouse): _____
Address: _____ City: _____ St. _____ Zip: _____
Relationship: _____ Phone No.: _____ Ext.: _____

INSURANCE INFORMATION:

Does your insurance cover maternity care? Yes No Deductible _____
Primary Coverage, Name of Carrier & Address _____ Secondary Coverage, Name of Carrier & Address _____
Group No.: _____ Group No.: _____
Identification No.: _____ Identification No.: _____
Subscriber Name: _____ Subscriber Name: _____
Subscriber's Birthdate: _____ Subscriber's Birthdate: _____
Effective Date: _____ Effective Date: _____
Are you covered by Medicaid? Yes No Please give secretary a current copy of Medicaid form.
Medicaid No.: _____

We ask all patients to show their insurance membership card so that we may copy them. Medicaid Card must be presented at each visit or payment is due the day of service. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections for insurance companies and will credit and such collection to the patients account.

I give my consent to **Family Care Associates of Effingham, S.C.** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of my family members. I have been informed and understand that I am personally responsible for the full payment of my account. In the event my account is past due more than 60 days, a finance charge will be assessed. If I have not made arrangements for payments after 90 days, I will be responsible for all fees incurred for collection and/or attorney fees. We require payment and/or co-payment the day of the service for all visits.

This application is for OB Care Only. If you need continuing medical care other than OB or Pediatric care after delivery, you need to fill out a separate application.

Signature: _____ Date: _____