STARK, McBRIDE, LOVE, WALLACE, VALICE, GOYMERAC & MORGAN

OBSTETRICS & GYNECOLOGY, P.C.

Patient Information

Last Name | First Name | Middle In. | Date of Birth / /

Address | City | State | Zip | Phone ( )

Marital Status: ☐ Single ☐ Married | Social Security Number – – | Cell Phone ( )

Emergency Contact: Name | Relation | Phone ( )

Insured's Information

Last Name | First Name | Middle In. | Date of Birth / /

Employer | Occupation | Phone ( )

Primary Insurance Information

Name of Subscriber | Group #

Contract # | Date Effective

Secondary Insurance Information

Name of Subscriber | Group #

Contract # | Date Effective

I agree that I shall be legally responsible for any medical or surgical charge incurred in excess of any hospitalization or health insurance that might be applicable. I assign payment of authorized benefits to Oakland-Macomb Obstetrics and Gynecology, P.C. I understand that I am responsible for the charges not covered by my policy.

RELEASE OF INFORMATION

I authorize Oakland-Macomb Obstetrics and Gynecology, P.C. to release any medical information required by my health insurance company to process a claim/claims.

CONSENT TO TESTING

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissue and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), I will be counseled by my physician and I will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable diseases is not required by law in situations where a heath care provider sustains an exposure to my blood or bodily fluids.

Signature of Patient or Legally Authorized Representative | Witness

Date | Name of Responsible Party's Employer

I voluntarily consent to receive all such medical treatment that my physician considers beneficial to me. I understand that this care may include diagnostic tests, examinations, medical or surgical treatment. I am aware that the practice of medicine is not an exact science, and I hereby acknowledge that no guarantees have been made to me as to the results or treatment and examinations provided.

You have the right to an Advance Directive (Durable Power of Attorney for Health care). Please check if you have the following:

☐ Durable Power of Attorney for Health care ☐ I don't have either, but would like more information ☐ I don't need that information

Patient Signature ______________________ Date __________

Witness ______________________ Date __________

MEDICARE PATIENTS ONLY

I request payment of authorized Medicare benefits to either myself or Oakland-Macomb Obstetrics and Gynecology, P.C. on my behalf for services rendered. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

Patient Signature ______________________ Date __________