

CONFIDENTIAL

ANNUAL UPDATE
 INFORMATION CHANGE

HENDERSON OB/GYN

129 W. LAKE MEAD HWY. STE. 19 * HENDERSON, NV 89015
PHONE: (702)568-6108 * FAX: (702)568-8603

◆ ◆ ◆ PLEASE PRINT ◆ ◆ ◆

Full Name: _____ Date of Birth: _____

Age: _____ Single Married Divorced Other: _____

Social Security Number: _____ Email: _____

Address: _____ Apt/Space/Unit# : _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ ext. _____

Employer: _____ Occupation/Dept: _____

Spouse/Guarantor SS#: _____ Spouse/Guarantor DOB: _____

Spouse/Guarantor Employer: _____ Occupation/Dept: _____

Person to Notify in Case of Emergency (NOT LIVING WITH PATIENT): _____

Phone #: (____) _____ Relationship to Patient: _____

◆ ◆ ◆ INSURANCE INFORMATION ◆ ◆ ◆

Primary Insurance Co: _____ Phone: (____) _____

Policyholder's Name: _____ Policyholder's DOB: _____

SS#: _____ ID#: _____ Group #: _____

Insurance Address: _____

Employer: _____ Work Phone: (____) _____ ext. _____

Relationship to Patient: Self Spouse Mother Father Legal Guardian Other _____

Secondary Insurance Co: _____ Phone: (____) _____

Policyholder's Name: _____ Policyholder's DOB: _____

SS#: _____ ID#: _____ Group #: _____

Insurance Address: _____

Employer: _____ Work Phone: (____) _____ ext. _____

Relationship to Patient: Self Spouse Mother Father Legal Guardian Other _____

PLEASE READ THE FOLLOWING CAREFULLY:

All deductible, co-payments and applicable charges will be due at the time of service- **NO EXCEPTIONS. All surgery fees MUST be paid in advance of the surgical date** – NO EXCEPTIONS.

NOTE: There will be a separate bill from the lab for PAP SMEAR interpretation, cultures, urinalysis and any other laboratory tests.

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. And I assign benefits, otherwise payable to me, to Henderson OB/GYN. All professional services rendered are charged to the patient. **The patient is responsible for all fees regardless of insurance coverage.** In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due to Henderson OB/GYN.

Patient/Legal Guardian Signature: _____ Date: _____

