

MAGNOLIA OBSTETRICS AND GYNECOLOGY, PLLC

LEANN E. HADDOCK, MD

KAMILIA T. SMITH, MD

DATE _____ ACCT# _____ (OFFICE USE ONLY)

LAST NAME _____ FIRST _____ MI _____

STREET ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP CODE _____

HM# _____ WK# _____ EXT _____

CELL # _____ E-MAIL _____

EMPLOYER/BUSINESS NAME _____ OCCUPATION _____

AGE _____ DOB _____ / _____ / _____ SS# _____ - _____ - _____ MARITAL STATUS _____

SPOUSE LAST NAME _____ FIRST _____ MI _____

RESPONSIBLE PARTY, SPOUSE OR INSURED INFORMATION

LAST NAME _____ FIRST _____ MI _____

AGE _____ DOB _____ / _____ / _____ SS# _____ - _____ - _____ RELATIONSHIP _____

EMPLOYER / BUSINESS NAME _____ OCCUPATION _____

WORK # _____ EXT _____ CELL# _____

EMERGENCY CONTACT _____ WORK _____

RELATIONSHIP _____ CELL _____

HOW DID YOU HEAR ABOUT US? _____

PHARMACY NAME _____ PHONE # _____

INSURANCE _____ TEL # _____

CLAIMS ADDRESS _____

EMPLOYER NAME _____ GROUP # _____

EMPLOYEE NAME _____ DOB _____ / _____ / _____

SS# / ID# _____ REL TO PT _____

SIGNATURE _____ DATE _____

I UNDERSTAND AND AGREE THAT PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME OF SERVICE, ANY OTHER ARRANGEMENTS MUST BE MADE PRIOR TO SERVICE. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS TO THE CONTRACTED PROVIDERS WITH MAGNOLIA OBSTETRICS AND GYNECOLOGY ASSOCIATES, LLP FOR CHARGES WHICH MAY BE BILLED ON MY BEHALF. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY ACCOUNT. I UNDERSTAND THAT ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE AND THAT I MAY BE BILLED FOR ANY BALANCE REMAINING AFTER MY INSURANCE PROCESSES ANY AND ALL CLAIMS.