Summit
OBSTETRICS & GYNECOLOGY, PSC
A Comprehensive Center For Women

Summit Obstetrics & Gynecology, PSC
1921 Leitchfield Road
Owensboro, KY 42303
270-478-5334

Patient Registration

PATIENT NAME: First / Last:		DOB	AGE	CELL PHONE
HOME ADDRESS		CITY	STATE	ZIP CODE
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE
EMPLOYER	ADDRESS			WORK PHONE
SPOUSE (OR PARENT)	SPOUSE (OR PARENT) EMPLOYER			SPOUSE (OR PARENT) WORK PHONE
PRIMARY CARE PHYSICIAN	ADDRESS			TELEPHONE
PREFERRED PHARMACY (NAME)	ADDRESS			TELEPHONE
EMAIL ADDRESS				

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS		POLICYHOLDER'S SOCIAL SECURITY	
	POLICYHOLDER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	POLICYHOLDER'S ADDRESS		WORK PHONE	POLICYHOLDER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS			
	POLICYHOLDER'S NAME	SEX	POLICYHOLDER'S DATE OF BIRTH	RELATIONSHIP TO PATIENT

HOW DID YOU HEAR ABOUT US?

☐ PHYSICIAN ______________________
☐ PATIENT/FRIEND
☐ HEALTH FAIR ____________________
☐WEBSITE/FACE BOOK
☐ INTERNET _______________________

☐ MESSENGER-INQUIRER
☐ OWENSBORO PARENT MAGAZINE
☐ BILLBOARDS
☐ NEWCOMERS AD/POSTCARD

☐ LOCAL DIRECTORY/which?______________________________
☐ OTHER:____

BILLING POLICY AND PATIENT AUTHORIZATION

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, credit card, or money order.

Cancellation of an appointment with less than 24 hours' notice or any appointment missed without prior notification may be subject to a $35 cancellation charge. After three missed appointments, the scheduling of future appointments will be at the discretion of the practice.

I, the patient named above, hereby authorize Summit Obstetrics & Gynecology, PSC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above-named carrier or me at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

____ Date:

____ Signature of Patient or Guardian: