Patient Profile

PATIENT INFORMATION

Name: BDS Test

Address: 55 Tozer

City, State, Zip: Beverly, MA 01915

Phone 1: (978) 555-2222 [ ]Home [ ]Work [X]Mobile

Please designate on phone #1 a number where we may leave a detailed message which may contain confidential information

Please sign acceptance

Phone 2: (978) 555-1213 [ ]Home [X]Work [ ]Mobile

Sex: [ ]M [X]F **Email:** bdstest@ecobgyn.org

Date of Birth: 1/1/1980 **Age:** 32

Marital Status [ ]Married [ ]Single [ ]Other

Preferred Language Vietnamese

PRIMARY INSURANCE

Insurance: CeltiCare

Insurance ID: Hi Mom 123

SECONDARY INSURANCE

Insurance: Fiserv Health

Insurance ID:

Doctor: David P DiChiara MD

Primary Care Physician: Brian D Silverio

Race:
[ ] American Indian or Alaska Native
[ ] Black or African American
[ ] Native Hawaiian
[ ] Pacific Islander
[ ] White
[X] Other
[ ] Undetermined
[ ] Declined

Ethnicity:
[ ] Hispanic or Latino
[ ] Non Hispanic or Latino
[X] Other or Undetermined

GUARANTOR INFORMATION

[X] Same as Patient

Name:

Address: 55 Tozer

City, State, Zip: Beverly, MA 01915

Date of Birth: 01/01/1980

Relationship to Patient: Self

Emergency Contact: Mortimer Q Snerd **Relationship** Emergency Contact **Phone**

Pharmacy:

Name: Stop & Shop Jamaica Plain - Ce

Phone: (617) 522-4300

Address:

City, State, Zip:

IF ABOVE INFORMATION IS CORRECT PLEASE SIGN.

SIGNATURE *DATE*

AUTHORIZATION OF BENEFITS FOR INSURANCE

Payment of any outstanding fees are requested at the time services are rendered. I agree to pay any and all charges that exceed insurance payment that are not covered by insurance. I understand that if I default on payment and my account is sent to a credit bureau or collection agency there will be services charges, equivalent to Essex County Obstetricians' additional costs, added to my existing balance due. I hereby authorize assignment and payment directly to Northeast Medical Practice for major medical and/or surgical benefits due to me.

If minor, please have parent / guardian sign.

SIGNATURE *DATE*

NOTICE OF HEALTH PRIVACY PRACTICES

I acknowledge that I have reviewed and understand Essex County Obstetricians' **Notice of Health Privacy Practices.** This notice describes how Essex County OB/GYN Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

If minor, please have parent / guardian sign.

10/04/2011

SIGNATURE *DATE*