

PUEBLO ASSOCIATES IN OBSTETRICS & GYNECOLOGY, P.C.

After reading and completing form, return to front counter with insurance card.

Physician _____

Primary Care Physician _____

Last Name _____ First _____ M.I. _____ Nickname _____

Address _____ City _____ State _____ ZIP _____

Home Phone (____) _____ Birthdate ____/____/____ Marital Status _____

Soc. Sec. # _____ Employer _____ Ph # _____

Spouse's Name _____ Spouse Employer _____

Spouse's Work Ph# _____ Spouse SS# _____

Spouse DOB ____/____/____

DEPENDENT CHILD

Mom: _____ Address _____ Ph# _____

Employer _____ Ph# _____

Dad: _____ Address _____ Ph# _____

Employer _____ Ph# _____

The responsibility for payment for services rendered to any dependent child whose parents are divorced rests with the parent seeking treatment. Our office cannot become involved in disputes over financial responsibility for a child's medical care.

HOW DID YOU SELECT OUR OFFICE? Phone Book _____ Friend or Relative _____ Physician _____

Other (please specify) _____

I will be paying today by CASH _____ CHECK _____ CREDIT CARD _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes of the above information. I authorize my physician to release to my insurance company all medical records necessary for billing purposes, utilization, review and quality assurance.

All payments are due at the time treatment is rendered unless prior arrangements have been made. As a courtesy, we file all applicable insurance claims for you. However, if your insurance denies payment on services, you are responsible for all charges. I agree to pay all reasonable rebilling fees, attorney fees and court costs associated with the collection of any debts as allowed by Colorado State Law.

Signature _____ Date _____