

Sunlife OB/GYN Services

PATIENT INFORMATION Informacion del Paciente

Patient Name: _____

Nombre del Paciente

Home Address: _____

Direccion del Hogar

City: _____ **State:** _____ **Zip Code:** _____

Ciudad

Estado

Codigo Postal

Occupation: _____

Ocupacion

Employer: _____

Empleo

Name of Spouse or Nearest Relative: _____

Contacto de Emergencia

Spouse/Relative Phone#: _____

Telefono de emergencia

Cell/Home Phone: _____

Telefono del Hogar

Work Phone: _____

Telefono del Trabajo

Date of Birth: _____ **Age:** _____

Fecha de Nacimiento

Social Security #: _____

Numero de Seguro Social

Email: _____

Direccion de correo electrónico

Marital Status: _____

Estado Civil

Primary Care Physician(PCP): _____

Nombre de su doctor primario

EMERGENCY CONTACT INFORMATION

(Please provide a contact name and number of someone we can call if you cannot be reached)

(Por favor proveer informacion de la persona que podemos contactar en caso de emergencia)

First and Last Name: _____

Primer Nombre y Apellido

Relation to you: _____

Relacion a usted

Phone: _____

Telefono

Work Phone: _____

Telefono del Trabajo

INSURANCE INFORMATION Informacion de Seguro

Name of Primary Insurance: _____

Nombre del Seguro

Primary Insurance ID#: _____

Seguro primario

Name of Subscriber: _____

Nombre del Asegurado

Relation to Patient: _____

Relacion al Paciente

Subscriber's SS#: _____

Numero de Seguro Social del Asegurado

Subscriber's Date of Birth: _____

Fecha de Nacimiento del Asegurado

Name of Secondary Insurance: _____

Nombre del Seguro Secundario

Name of Subscriber: _____

Nombre del Asegurado

Relation to Patient: _____

Relacion al Paciente

Secondary Ins ID #: _____

Seguro Secundario

Subscriber's SS#: _____

Numero de Poliza

Subscriber's Date of Birth: _____

Fecha de Nacimiento del Asegurado

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs. **Spanish:** Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby assign payment directly to Sunlife OB-GYN Services of Fort Lauderdale ("Sunlife") of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Sunlife. I understand that I am financially responsible to Sunlife for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit; Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits. **Spanish:** Por la presente autorizo el pago directamente a Sunlife OB-GYN Services of Fort Lauderdale ("Sunlife") todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S SIGNATURE & NOTICE OF PRIVACY ACKNOWLEDGEMENT: I have read and understand the Privacy Act:

Signature Firma del Paciente: _____ **DATE:** _____