Renée C. Smith M.D., FACOG
Wise Obstetrics & Gynecology, P.A.

Date:_____ Private Password_____
[something only you will know to help us identify you when you call]

Account#:_____

Name_____ SS#____-____-_____DOB_____Age_____

Address_____
Street/PO Box City State Zip

Home#_____ Cell#_____Work#_____
Pharmacy used _____
Employer_____
Marital Status: Single_____Married_____Divorced_____Widowed_____
Spouse's Name_____ Spouse's DOB_____

Person Responsible for Payment
Responsible Party's Name_____DOB_____
SS#_____Relationship to Patient_____
Home Phone#_____ Work Phone#_____
Responsible Party's Address_____
_____
Employer_____

Medical Insurance Information
Insurance Company Name_____
ID# of Insured_____Group #_____
Insured's Name_____DOB_____
SS#_____Employer_____
Secondary Insurance Co. Name_____
ID#_____Group #_____

Emergency Contact
Name_____Relationship_____Phone#_____
How did you hear about us?_____

Release of Records
I hereby authorize the release of any necessary information obtained in my medical record to my insurance carrier or any other facility providing medical services or goods.
Signature_____Date_____

Financial Responsibility Statement
I hereby authorize my insurance benefits to be paid directly to Renee Smith, MD, understanding that if my services are not covered by my insurance, I may be responsible to pay. If I do not have insurance and am private pay, I understand that I am responsible for payment at time services are rendered.

Signature_____Date_____