Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

PATIENT REGISTRATION

(PLEASE PRINT; COMPLETE **ALL ITEMS** THOROUGHLY)

PATIENT INFORMATION

PATIENT NAME _____ _____ AGE _____
(LAST) (FIRST) (MI)

HOME PHONE _____ WORK _____ CELL _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP) (COUNTY)

DOB _____ SS# _____ MARITAL STATUS _____

Who referred you to us? MD / FAMILY / FRIEND / YELLOW PAGES / OTHER _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PREFERRED PHARMACY _____ PHONE _____

ADDRESS _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

NAME OF SPOUSE _____ SPOUSE'S EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____
(NAME) (PHONE) (RELATIONSHIP)

ADDRESS _____

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ ADDRESS _____

SIGNATURE _____ **DATE** _____

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INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE COMPANY _____	INSURANCE COMPANY _____
POLICYHOLDER'S NAME_____	POLICYHOLDER'S NAME _____
SS#_____ DOB_____ SEX___	SS#_____ DOB_____ SEX___
POLICY#_____GROUP# _____	POLICY#_____GROUP# _____
EMPLOYER/GROUP NAME _____	EMPLOYER/GROUP NAME _____

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have read, understand and have been provided with a copy of our notice of privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing or by reviewing the current copy in our waiting room. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You authorize Sandhills OB/GYN to release your personal health information to:

_____

Name Address Phone Number

_____

Name Address Phone Number

_____

Signature of Patient/Legal Guardian Relationship to Patient Date

_____ _____

Patient/Legal Guardian Name Printed Witness Signature Date

Financial Agreement

I certify that all of the information provided is correct. I hereby authorize direct payment of surgical/medical benefits to Sandhills OB/GYN for services rendered by them in person or under their supervision. It is my responsibility to notify the insurance company prior to admission if precertification is necessary. I understand that I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I further understand that if my account is turned over to a collection agency, finance charges of 1.5% per month (18% per year) will be added to invoices.

Consent for Treatment

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I hereby agree and give consent to the treating physician and employees of this office and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as determined necessary and appropriate by the treating physician, his/her partner, associates, and consultants.

I agree to and give my consent to all of the above information.

Signature of Patient/Legal Guardian | Relationship to Patient | Date

Patient/Legal Guardian Name Printed | Witness Signature | Date