

STEPHEN R. STANLEY, D.O.

OBSTETRICS AND GYNECOLOGY

PATIENT INFORMATION			
LAST NAME		SOCIAL SECURITY NUMBER	
FIRST NAME	MIDDLE INITIAL	SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/>
MAILING ADDRESS		DATE OF BIRTH	
CITY	STATE	HOME PHONE	
IF THE ABOVE ADDRESS IS A P. O. BOX, WHAT IS YOUR STREET ADDRESS			WORK PHONE
CITY	STATE	CELL PHONE	
YOUR EMPLOYER			
WORK ADDRESS			
CITY	STATE	ZIP	
PRIMARY CARE PHYSICIAN:			
SPOUSE OR SIGNIFICANT OTHER INFORMATION			
LAST NAME		SOCIAL SECURITY NUMBER	DATE OF BIRTH
FIRST NAME		MIDDLE INITIAL	
EMPLOYER			WORK PHONE
WORK ADDRESS			
CITY	STATE	ZIP	
WHO TO CONTACT IN CASE OF EMERGENCY			
NAME	HOME PHONE	CELL PHONE	RELATIONSHIP
INSURANCE INFORMATION: PRIMARY			
INSURED NAME		RELATIONSHIP TO PATIENT:	DOB
INSURANCE COMPANY			
INSURANCE INFORMATION: SECONDARY			
INSURED NAME		RELATIONSHIP TO PATIENT	DOB
INSURANCE COMPANY			

ASSIGNMENT AND RELEASE:

I hereby authorize Dr. Stephen R. Stanley to apply for benefits on my behalf for services rendered to me and request that payment be made by my Insurance Company and be sent directly to Dr. Stephen R. Stanley. I understand that this no way relieves me of my primary responsibility to pay for services rendered to me and if my account is turned over for collection, I agree to pay any reasonable legal fees, court costs, interest at the maximum rate allowed by state law and other expenses incurred as a result of said collection. I also authorize Dr. Stephen R. Stanley to release information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

PATIENT'S SIGNATURE

DATE