Form No. 1

OBSTETRICS **PATIENT REGISTRATION & HEALTH QUESTIONNAIRE**

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE (HOME)	(WORK) OK TO CALL WORK YES / NO	OCCUPATION/ EMPLOYER	
PATIENTS SOC.SEC. #		REFERRED BY	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE #
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT / NEXT OF KIN (OTHER THAN SPOUSE)	PHONE	ADDRESS	RELATION

INSURANCE AND BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)			RELATIONSHIP
BILLING ADDRESS			PHONE #
SOC. SEC. # OF CARD HOLDER			

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	I.D. #	GROUP #	BENEFIT CODE
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
SUBSCRIBER'S NAME	I.D. #	GROUP #	BENEFIT CODE
MEDICARE#	MEDICADE I.D. #		
OTHER COVERAGE			

I authorize **Gary D. Ott, M.D., Heather L. Sholtis, D.O., Kelly Duckett, D.O.,** or their staff representative, to talk to
___my spouse, ___my children, ___my parents, ___siblings, or any other person I have listed here_____________________________________concerning my care at his office. This may include biopsy results, lab reports, evaluation results, diagnosis, and/or treatment plans.

Signature______________________________________ Date________________

Gary D. Ott, M.D. and his staff may leave messages on my answering machine if unable to reach me directly.

_____Yes _____No Please **initial** either answer.