

# LINCOLN CENTER OBSTETRICS & GYNECOLOGY

Chart Number: \_\_\_\_\_

Lincoln Center Physician: \_\_\_\_\_

**PATIENT INFORMATION** (please notify our office of any changes in the following information)Name: \_\_\_\_\_  
Last First Middle SuffixAddress: \_\_\_\_\_  
(IF PO BOX, **WE MUST ALSO HAVE HOUSE ADDRESS**)

City / State / Zip: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Social Security Number Date of Birth Marital Status Primary Care Physician

Home Phone Work Phone, Extension Cell Phone Referring Physician

Email Address Employer Occupation

Preferred Language

**ETHNICITY:**\_\_\_\_ **Hispanic or Latino**  
\_\_\_\_ **Not Hispanic or Latino**  
\_\_\_\_ **Decline to Answer****RACE:**\_\_\_\_ **American Indian or Alaska Native**  
\_\_\_\_ **Asian**  
\_\_\_\_ **Black or African American**  
\_\_\_\_ **Native Hawaiian or Other Pacific Islander**  
\_\_\_\_ **White**  
\_\_\_\_ **Decline to Answer**

Name of Parent, Spouse, Nearest Friend or Relative

How Related

Their Home Phone Their Work Phone, Extension Their Cell Phone

**IF INSURANCE REQUIRES A REFERRAL, PLEASE HAVE IT WITH YOU OR HAVE IT MAILED TO US**

Health Insurance Company (Primary) Effective Date Policy ID Number Group Number

Name Policy is Under Their Date of Birth Their Employer Their Sex

Health Insurance Company (Secondary) Effective Date Policy ID Number Group Number

Name Policy is Under Their Date of Birth Their Employer Their Sex

**OFFICE CREDIT POLICIES:**

Payment is requested when service is rendered. OB patients without insurance must have their estimated fee paid in full by delivery date. I hereby assign benefits from Medicare/Medigap/Medicaid/my health insurance(s) to the Lincoln Center physicians, Field-Kresie, Trobough, Gleason, Dickson, Bonebrake, Teply, Morrison and Brey, for all services billed to Medicare/Medigap/Medicaid/my health insurance company(s) for which I have not paid in full. A copy of this assignment shall be as valid as an original. I understand I will be financially responsible for any services considered to be non-covered by Medicare/Medigap/Medicaid/my health insurance company(s). If my account is turned over to a collection agency, I understand that I may be subject to interest charges. I authorize the release of any medical information necessary to process my claims, and for Utilization Review/Chart Audits that may be required under the guidelines of Medicare/Medigap/Medicaid/my health insurance company(s). It is understood and agreed that the physicians of Lincoln Center OB/GYN, PA have the right to designate which practitioner(s) will perform medical services requested by the undersigned patient.

**DATED:** \_\_\_\_\_**SIGNED:** \_\_\_\_\_