Olathe OB/GYN Patient Information Form
DOUGLAS B. MACFARLANE, M.D., A.F.O.G.

PLEASE COMPLETE THE FOLLOWING:

DATE_____ REFERRED BY_____ FAMILY DOCTOR_____

LEGAL NAME_____ MAIDEN_____
First (M.I.) Last

BIRTHDATE_____ AGE_____ SS#_____ DL#_____

CURRENT ADDRESS_____ CITY_____ STATE_____

ZIP_____ HOME # ( )_____ WORK # ( )_____ CELL # ( )_____

OTHER THAN MYSELF YOU MAY LEAVE A MESSAGE WITH:_____ DAYTIME # _____

EMPLOYER_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ OCCUPATION_____

MARITAL STATUS: S M D W SPOUSE/PARENT_____ BIRTHDATE_____

SPOUSE/PARENT SS #_____ HOME # ( )_____ WORK # ( )_____

EMERGENCY CONTACT/RELATIONSHIP _____ CELL # / WORK # ( )_____
(Other than your spouse)

To avoid a $10 rebilling fee, you must provide accurate, complete insurance information

_____
initial

INSURANCE INFORMATION

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

EMPLOYEE _____ EMPLOYEE_____

EMPLOYEE D.O.B._____ SS#_____ EMPLOYEE D.O.B._____ SS#_____

EMPLOYER_____ EMPLOYER_____

Authorization to release information: I hereby authorize the release of any medical information necessary to process all claims for charges incurred at Olathe OB/GYN.

Authorization to pay benefits to physician: I assign payment directly to Olathe OB/GYN for the medical and / or surgical benefits, if any, otherwise payable to me for services as described above but not to exceed my indebtedness to Olathe OB/GYN for those services. I understand I am financially responsible for charges not covered by my insurance. _____ initial

Financial Agreement: I agree that I am financially responsible for all charges not covered by my insurance company, included but not limited to medical services deemed routine, elective or not medically necessary by my insurance company and / or any co-pays, deductibles, coinsurance amounts or non-covered items specified by my insurance company.
Notice of Privacy Practices: I acknowledge that I have read and understand the content of the Notice of Privacy Practices.

To avoid a $25.00 fee, I must notify the office within 24 hours of an appointment should I be unable to keep it. _____initial

X_____

Signature of Patient or Guardian Date