OB/GYN Specialists of Lima, Inc.
Kindness, Compassion, Excellent Care
830 West High Street, Suite 101 & 304
Lima, Ohio 45801-3968
419-227-0610
1-800-686-4096
FAX 419-228-3273

Please complete this form carefully. If you have any questions please ask our staff for assistance. In addition to this information, we will ask for a copy of your insurance card at each visit. Please be prepared to pay insurance co-payments at each visit.

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS

First name:_____ M:_____Last Name:_____

Marital Status:_____ Maiden Name:_____

Home Address:_____

City, State, and Zip Code:_____

DOB:_____ Age_____ SSN:_____

Please Check Box on which Phone Number is your Primary Number:
□Home#_____ □Cell:_____ □Work:_____

Email:_____

Employer:_____ Occupation:_____

Student Status: □N/A: □ Full Time: □ Part Time: Name of School:_____

Family Physician:_____

Pharmacy Name_____ Location:_____

May we leave a message on your voicemail? (Regarding appointment reminders or normal lab results?) YES□ NO□

Emergency Contact (someone living outside of home):_____

Relationship:_____ Phone number:_____

By signing below you authorize for us to follow the above guidelines regarding our method of contact for you in regards to appointment reminders and lab results.

_____ _____
Name (Signature of Patient OR Guardian) Date

Insurance Information: **(Please provide information even if we make a copy of your card.)**

Primary Ins: _____ Member ID #_____ Group#_____

Subscribers Name_____ DOB:_____

Subscribers SSN:_____

Secondary Ins: _____ Policy #_____ Group#_____

Subscribers Name_____ DOB:_____

Subscribers SSN:_____

Disclosures/ HIPAA

Our policy here at OB/GYN Specialists of Lima, Inc. is not to disclose any of your private health care information to your family members, friends, or loved ones. We will be unable to release any information about your health care without your written consent. This includes information to parents, significant others, friends, spouse, or other relatives. If you wish to have your private health care or treatment information released to another individual you must read and complete the following:

Authorized Person(s):

Name:_____ Relationship:_____

DOB: _____ Phone Number:_____

Name:_____ Relationship:_____

DOB:_____ Phone Number:_____

Name:_____ Relationship:_____

DOB:_____ Phone Number:_____

I authorize the above named health care provider to release the information specified below to the organization/agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication to appropriate individual. I understand that with this authorization, all information contained in my chart/file may include psychosocial/psychiatric information unless otherwise indicated.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by privacy regulations, the information described above may be disclosed and is no longer protected by those regulations.

I understand that this authorization will remain valid indefinitely unless otherwise revoked by me in writing. I also understand that I may revoke this authorization in writing at any time by notifying the Privacy Officer, except to the extent that action has already been taken in reliance on this authorization.

_____ _____

Name (Signature of Patient OR Guardian) Date