GENESIS OB/GYN

INSURANCE FORM
(Please Print)

PRIMARY INSURANCE & BILLING INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate Primary Insurance:					
Subscriber's name:	Birth date:	Billing Address (if different):			
Home phone number: ( )		Is it ok to leave a message? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Subscriber's S.S. Number:	Birth date:	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

SECONDARY INSURANCE & BILLING INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate Secondary Insurance:					
Subscriber's name:	Birth date:	Billing Address (if different):			
Home phone number: ( )		Is it ok to leave a message? ☐ Yes ☐ No			
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Subscriber's S.S. Number:	Birth date:	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

The above information is accurate to the best of my knowledge. I give my insurance permission to pay benefits to the physician. I am aware of my financial responsibility for any balance I owe. Additionally, I approve any release of my information by Genesis OB/GYN or my insurance company necessary to process my claims.

In order to control our costs of billing we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

Patient/Guardian Signature   Date

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