Print Form

Centennial Ob/Gyn

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Patient Information

Date: MRN: Referred by:

Name: Marital Status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Birth Date: Age: Social Security #:

Street Address:

City: State: Zip code: Home Phone:

Cell Phone: Work Phone: Primary Physician:

Email: Occupation:

Employer: Employer Address:

Person to contact in case of emergency (not living at same address):

Relationship to Patient: Phone:

How did you hear from us: ☐ Doctor ☐ Insurance plan ☐ Hospital ☐ Relative

☐ Friend ☐ ZocDoc ☐ DexKnows.com ☐ Yellowpages.com ☐ Centennialobgyn.com

☐ Angie's List ☐ Google ☐ Other

Guarantor Information

Person responsible for bill: Relationship to Patient:

Address:

Birth Date: Home Phone: Social Security #:

Employer: Employer Phone: Occupation:

Employer Address:

Insurance Information

Primary Insurance Co: Subscriber's Name:

Subscriber's Social Security #: Birth Date:

Group No: Policy No: Relationship to Patient:

Effective Date: Employer: Work Phone:

Insurance Address:

Secondary Insurance Co: Subscriber's Name:

Subscriber's Social Security #: Birth Date:

Group No: Policy No: Relationship to Patient:

Effective Date: Employer: Work Phone:

Insurance Address:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn). I understand that I am financially responsible for any fees regardless of insurance coverage. I authorize Luis López-Benítez, M.D., Ltd. (Centennial Ob/Gyn) and/or the insurance company to release any information required to process my claims. I also understand in the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account. There will be a $35 fee for all appointments not cancelled at least 24 hours prior to the appointment time.

Patient/Guardian Signature: _____ Date: