



**Annual Patient Registration**

Name: First	M.	Last	Date of Birth	Age	Marital Status	SSN (optional)
Address: Street			City	State	Zip	
Patient Employer		Home Phone	Work Phone	Cell Phone		
Where would you like us to reach you?			OK to leave a detailed message?			

Primary Insurance	Policy Holder	Relationship to Patient	
Policy Holder's Employer	Work Phone	SSN (optional)	Date of Birth
Policy Holder's Employer's Address	City	State	Zip
Secondary Insurance	Policy Holder	Relationship to Patient	
Policy Holder's Employer	Work Phone	SSN (optional)	Date of Birth
Policy Holder's Employer's Address	City	State	Zip

*If you would like someone other than yourself and your Physician to access your medical information, list here:* \_\_\_\_\_

**Patient Contract**

**Greenbriar Ob/Gyn, P.C. will file medical claims to contracted insurance companies *when provided with correct and current information.* If the patient does not have the Policy Holder's Information requested above or does not present a valid insurance card at the time of service, the Patient must pay the entire amount at time of service.**

Greenbriar Ob/Gyn, P.C. is not responsible for determining the amount of the co-pay, deductible, or other amounts designated by the insurance company as the responsibility of the Patient of the Policy Holder. Co-Payment is due at the time of service.

Guarantor accepts responsibility for any and all charges for medical treatment rendered by Greenbriar Ob/Gyn, P.C.

Patient authorizes Greenbriar Ob/Gyn, P.C. to release information concerning her health and treatment to the contracted insurance company. Patient authorizes the insurance company to release to Greenbriar Ob/Gyn, P.C. any information pertinent to her care, benefits, and precertification. The undersigned assigns to Greenbriar Ob/Gyn, P.C. all payments for medical services rendered. The undersigned authorizes Greenbriar Ob/Gyn, P.C. to contact me by mail or by phone regarding billing statements and appointment reminders.

All information given above is correct to the best of my knowledge.

_____ Patient Signature	_____ Date	_____ Guarantor Signature	_____ Date
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