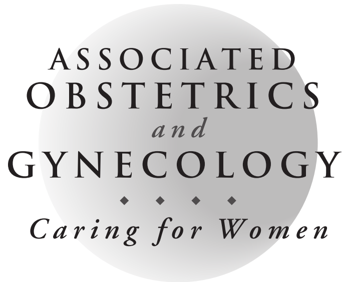

Stanley Dorfman, M.D.
Robert Robins, M.D.
William H. Jewell, Jr., M.D.
Paul J. Corsi, M.D.
Patricia Kondratenko, D.O.

General Information

Office Use Only

Patient # ______________ Date ________

Name ____ ❍ Single ❍ Married ❍ Divorced ❍ Widowed

Address ______________________________________ City ________________ State _____ ZIP ________

Home # ______________________ Cell # ______________________ email ___________________________

DOB ____________ SS # ______________________ Driver's License # ______________________________

Insurance Carrier _________________________________ Insurance # ________________________________

Employer Name _______________________________________ Office # ____________________________

Address ______________________________________ City ________________ State _____ ZIP ________

Person(s) to Contact ____

____

Referred By ____

Please fill out information below for spouse or party responsible for payment.

Name __________________________________ DOB ___________ Relation to Patient __________________

Address ______________________________________ City ________________ State _____ ZIP ________

Home # _____________________ Business # ____________________ SS # ___________________________

Employer Name _______________________________________

- I authorize release of all my medical records to the referring physician, my insurance company, or to other physicians for the purpose of continuation of care.
- I understand that payment of charges incurred is due at the time of service.
- I authorize my insurance company to pay directly to Associated Obstetrics & Gynecology, P.C., if they are participating physicians in my insurance plan.
- I acknowledge full financial responsibility for services rendered by Associated Obstetrics & Gynecology, P.C.
- I authorize treatment of my dependant by Associated Obstetrics & Gynecology, P.C. and agree that I will be responsible for any fees incurred.
- I have read and fully understand the above financial responsibility, release of medical information and insurance authorization.

Signature ____ Date _______________

Signature of Guardian ____ Date _______________