CENTRAL IOWA OB/GYN SPECIALISTS

2501 Westown Parkway #1101 West Des Moines, IA 50266

Name: _____ Age: _____ Date of Birth: _____

Maiden name _____ Phone # _____

Address: _____ Cell # _____

City/State: _____ Zip _____ SS #: _____

Email: _____ Preferred contact: Email ___ Text ____ Phone ____

Referring or Family Physician _____ Marital Status: Single Married

Did this physician refer you here : Yes _____ No_____ Divorced Widowed Separated

---

Employer: _____ Address: _____

Occupation: _____ Phone #: _____

Spouse/Guarantor _____ Date of Birth: _____ SS#: _____

Employer: _____ Address: _____

Occupation: _____ Phone #: _____

CONTACT IN CASE OF EMERGENCY (Friend or Relative, other than spouse)

Name: _____ Relationship: _____

Home Phone: _____ Cell or Work Phone # : _____

INSURANCE

Policy Holder: _____

Primary Insurance: _____ Relationship to Insured: _____

Claims Address: _____ Policy Holder DOB _____

_____ Policy Holder SS# _____

Phone #: _____ Eff Date: _____ ID # _____

Secondary Ins: _____ Policy Holder: _____

Claims Address: _____ Policy Holder DOB _____

_____ Policy Holder SS# _____

Phone #: _____ Eff Date: _____ ID # _____

Does your insurance require a specific lab or hospital? _____ Name: _____

Does your insurance carrier require notification upon admission to the hospital? YES ____ NO____

PAYMENT OF COINSURANCE AND COPAYS ARE EXPECTED AT TIME OF SERVICE

I understand that I am personally responsible for the amount not paid by insurance, including co-payments and deductibles which are paid at the time of service.

I hereby authorize the release of any information acquired in the course of my examination or treatment for the processing of insurance claims. I also request that payment of all insurance benefits be made to Central Iowa OB/Gyn Specialists for any services provided to me by them.

Signature: _____ Date: _____

(Patient or Responsible party)