NORTHWEST PROFESSIONAL OBSTETRICS & GYNECOLOGY
Richard J. Levy, M.D., F.A.C.O.G.
Karen L. Collins, M.D., F.A.C.O.G
Wendy D. Allen, M.S., A.P.N., C.N.M
Floy Haschke, M.S., A.P.N., C.A.N.P.

PATIENT PROFILE INFORMATION FORMS
(PLEASE PRINT)

DATE:_____

PATIENT'S NAME:_____
LAST FIRST MIDDLE

Date of Birth:_____ **Social Security Number**:_____ **Marital Status**: __S__M__D

ADDRESS:_____
STREET APT# CITY STATE ZIP

PRIMARY CONTACT NUMBER: ( )_____ Home Cell/Mobile Work

SECONDARY CONTACT NUMBER: ( )_____ Home Cell/Mobile Work

OCCUPATION:_____ **EMAIL ADDRESS**:_____

EMPLOYER:_____
NAME ADDRESS

SPOUSE NAME:_____ **SPOUSE OCCUPATION**:_____

RESPONSIBLE PARTY(INSURANCE HOLDER):_____

RESPONSIBLE PARTY'S SS#: _____ **RELATION TO YOU**: _____

RESPONSIBLE PARTY'S EMPLOYER: _____
NAME ADDRESS

RESPONSIBLE PARTY'S WORK PHONE: ( )_____

NAMES AND DATES OF BIRTH OF YOUR CHILDREN:

_____ _____

_____ _____

PRIMARY CARE PHYSICIAN:_____
NAME PHONE NUMBER

WHO REFERRED YOU TO OUR PRACTICE:_____

EMERGENCY CONTACT: _____
NAME PHONE NUMBER

Please complete page 2

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY:_____

INSURED NAME:_____

ID/SS#:_____ **GROUP NAME/#**:_____

SECONDARY INSURANCE COMPANY:_____

INSURED NAME:_____

ID/SS#:_____ **GROUP NAME/#**:_____

We will photocopy the front and back of your insurance card(s).

I designate
NORTHWEST PROFESSIONAL OBSTETRICS AND GYNECOLOGY, LTD.
RICHARD J. LEVY, M.D., F.A.C.O.G.
KAREN L. COLLINS, M.D., F.A.C.O.G.
As my woman's principal health care provider.

Signed:_____ Dated:_____

NORTHWEST PROFESSIONAL OBSTETRICS AND GYNECOLOGY, LTD. will file an insurance claim using carrier information I have supplied today. I understand that if my insurance denies or does not consider my claim, I am fully and personally responsible for payment. Signature of patient or authorized person certifies financial responsibility for all medical services provided and authorizes release of medical or other insurance information necessary for the processing of medical claims for payment by the carrier. Patient or authorized person acknowledges and understands that interest will be charged in the amount of 1.75% per month (21% annually) on all past due amounts.

Signed: _____ Dated:_____