



Centennial OB/GYN, P.A.

Leslie S. Welborne, M.D.

Melissa K Bailey M.D.

PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION

Patient Last Name		First Name			MI
Street Address	Apt.#	City	State	Zip	
Birth date	SSN				
Home Phone	Work phone	Cell Phone / Other			
Driver license number		Email Address			
Emergency Contact Name			Relationship to Patient		
Phone					
Student Status: Full-time / Part-time / Not a Student (circle one)					
Employer					

PRIMARY INSURANCE INFORMATION

Primary Insurance _____ Policyholder _____

Policy holder's DOB _____ Policy holder's SSN _____

Patient's Relationship to Policy holder _____ Policy Effective Date _____

Claims Address _____ MemberID# _____

Policyholder's Employer _____ Group # _____

Employer's Address _____ City _____ St _____ Zip _____

SECONDARY INSURANCE INFORMATION

Primary Insurance _____ Policyholder _____

Policy holder's DOB _____ Policy holder's SSN _____

Patient's Relationship to Policy holder _____ Policy Effective Date _____

Claims Address _____ Member ID # _____

Policyholder's Employer _____ Group # _____

Employer's Address _____ City _____ St _____ Zip _____

Authorization for Payment and to Release Information

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health plans to **Centennial OB/GYN, P.A.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information needed to secure payment.

Signature _____ Date _____

