COPPERSTATE OB/GYN ASSOCIATES LTD.

Women's Health Specialists

5550 E. Hampton St.
Tucson, AZ 85712
Phone: 520-721-8605
Fax: 520-721-4209
copperstateobgyn.com

PATIENT INFORMATION:

Your appt is with Doctor _____ Referred by _____

Patient Name _____ (circle one) MS MRS MISS

Date of Birth _____ / _____ /_____ Soc Sec Number _____ Marital Status (circle one) S M D W

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Primary Phone (_____) _____

Employer _____ Occupation _____ Phone (_____) _____

Emergency Contact _____ Phone (_____)_____ Relationship to Patient _____

COPPERSTATE WILL ASSIST YOU IN FILING WITH YOUR INSURANCE COMPANY IF ALL INFORMATION TO PROCESS A CLAIM HAS BEEN PROVIDED. THIS INCLUDES THE PLAN NAME, BILLING ADDRESS, NAME, DOB, AND SS# OF THE POLICY HOLDER, GROUP #'S, AND ANY OTHER INFORMATION NECESSARY TO FILE TO YOUR INSURANCE COMPANY (PROVIDE COPY OF CARD)

Primary Insurance _____ ID# _____

Group #_____ Co-pay _____ Effective Date _____

Policy Holder _____ Relationship _____

Policy Holder's: Date of Birth _____ SS# _____

Secondary Insurance _____ ID# _____
(if any)
Group # _____ Co-pay _____ Effective Date _____

Policy Holder _____ Relationship _____

Policy Holder's: Date of Birth _____/_____/_____ SS#_____

I AUTHORIZE COPPERSTATE OB/GYN ASSOCIATES TO RELEASE INFORMATION NECESSARY TO PROCESS CLAIMS AND ASSIGN INSURANCE BENEFITS TO BE PAID DIRECTLY TO COPPERSTATE OB/GYN. I UNDERSTAND THAT COPPERSTATE BILLS MY INSURANCE AS A COURTESY AND I AGREE TO BE RESPONSIBLE FOR ANY SERVICES THAT ARE DENIED OR ARE NOT COVERED. I UNDERSTAND THAT COPPERSTATE MEETS ALL MEDICARE AND HIPPA COMPLIANCE GUIDELINES AND WILL MAINTAIN CONFIDENTIALITY IN DEALING WITH MY PERSONAL/MEDICAL INFORMATION

SIGNATURE _____ DATE _____/_____/_____

COPAYS ARE DUE AT THE TIME OF THE VISIT. THERE IS A $25.00 SERVICE CHARGE FOR RETURNED CHECKS.