OBSTETRICAL ASSOCIATES OF ST. LOUIS, INC.

PLEASE FILL OUT FORM COMPLETELY

Appointment is with:

___ Daniel G. Wagner, M.D.
___ William E. Houck, M.D.
___ M. Bryant Thompson, M.D
___ Michelle E. Burk, WHNP
___ Jeffrey B. Thompson, M.D.
___ Paul G. LaPoint, M.D.
___ Laura I. Moore, M.D.
___ Heather M. Siebers, WHNP

____ Bring with you
____ Mail to office
____ St. Luke's
____ O'Fallon/Winghaven
____ Union

INITIAL DEMOGRAPHIC QUESTIONAIRE

(Please print)

Patient's Name: _____ Appointment Date: _____
(Last) (First) (Middle) (Maiden)

Home Address: _____ Cell Number: ( ) _____

City: _____ State: _____ Zip: _____ Home Telephone: ( )_____

Birthdate: _____ Age: _____ Marital Status: S M D W (circle one)

Occupation: _____ Social Security Number: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Work Telephone: ( )_____

Referring or Primary Care Physician (include address):_____

Referred to this office by: _____

Preferred Pharmacy (name)_____(address)_____(telephone)_____

In case of an emergency, contact: _____ Relationship: _____

Home phone: ( ) _____ Work phone: ( ) _____

BILLING AND INSURANCE INFORMATION

Name of Spouse: _____ Birthdate: _____ Age: _____

Occupation: _____ Social Security Number: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Telephone: ( ) _____

PRIMARY INSURANCE:

Name & Address of Company: _____

City: _____ State: _____ Zip: _____

Insured's Name _____ Effective Date of coverage: _____

DOB: _____ SSN: _____

Group No.: _____ Policy ID No.: _____

SECONDARY INSURANCE:

Name & Address of Company: _____

City: _____ State: _____ Zip: _____

Insured's Name _____ Effective Date of coverage: _____

DOB: _____ SSN: _____

Group No.: _____ Policy ID No.: _____

Our office will file insurance for your charges. Office visit co pays are payable on the day you are seen. Please remember you are responsible for all fees, regardless of your insurance coverage. We accept the following methods of payment: Cash/Check/MasterCard/Visa/Discover/American Express.

I authorize the release of any protected health information (PHI) necessary to process this claim. In addition to the foregoing, I hereby authorize the release of my protected health information (PHI) by or between any of my treating physicians and my insurer, HMO, health benefits payer or any other entity (including but not limited to third party administrators, management companies and provider networks) involved in the administration of my health benefits.

Signed: _____ Date: _____
(Patient or authorized person)

I authorize payment of medical and surgical benefits to Obstetrical Associates of St. Louis, Inc. on behalf of Dr._____.

Signed: _____ Date: _____
(Patient or authorized person)