Welcome To Our Office

PLEASE PRINT AND COMPLETE ALL PARTS

Central Obstetrics & Gynecology
Robert J. Wester, M.D. PC

Patient Number ____________ **Date** ____________

PATIENT NAME: (This section refers to PATIENT ONLY)

Name ____________ Age____ Date of Birth ___/___/___ SS # _____-_____-_____

Address ____________ Unit/Apt #________ City ____________ State ______ Zip __________

Home Phone ____________ Cell ____________ Work ____________

Email address: ____________

Occupation ____________ Employer ____________

Spouse ____________ Occupation ____________ Employer ____________

RESPONSIBLE PARTY: (Person who carries insurance and/or person who should receive the bill.)

Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Partner ☐ Daughter

☐ Check mark here if all the information is the same as above

Name ____________ Date of Birth ___/___/___ Employer ____________

Address ____________ Unit/Apt #________ City ____________ State ______ Zip __________

Home Phone ____________ Cell ____________ Work ____________

BY WHOM WERE YOU REFERRED? ____________

WHO IS YOUR PRIMARY CARE PHYSICIAN? ____________

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance ____________
Claims Address ____________
City, State, Zip ____________
Phone ____________
Primary Insured Person ____________
ID/Policy # ____________
Group # ____________
Employer ____________

Secondary Insurance ____________
Claims Address ____________
City, State, Zip ____________
Phone ____________
Primary Insured Person ____________
ID/Policy # ____________
Group # ____________
Employer ____________

NOTIFY IN EMERGENCY:
Name ____________ Relationship ____________ Phone ____________

CONSENT FOR TEST RESULTS: I give Robert J. Wester, M.D. PC, permission to leave all X-ray, lab results, test results, and other medical information and advice on: **(check all that apply)**

☐ Voice mail at work ☐ Voice mail at home ☐ Voice mail on cell ☐ Other ____________ ☐ Do not leave message

I hereby acknowledge that I have received a copy of Robert J. Wester, M.D.,P.C. Notice of Privacy Practices.

I hereby authorize my insurance benefits to be paid directly to Robert J. Wester, MD PC, realizing I am responsible for all dates of services (covered and non-covered covered) and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient Name ____________ Signature ____________ Date ____________

Relationship to patient: ☐ Self ☐ Parent ☐ Guardian