

# Patient Information Sheet

Office Use Only

**Wilkerson Obstetrics & Gynecology, P.A.**  
**Raleigh, N. C. 27607**

Patient # \_\_\_\_\_

Doctor # \_\_\_\_\_

Today's Date \_\_\_\_\_

## Please Print

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth     /     /      
First Middle Maiden Last M D YEAR

Child  Single  Married  Divorced  Separated  Widow

Street Address: (not a P.O. Box) \_\_\_\_\_  
Street Apt#

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ In Case of Emergency # \_\_\_\_\_

Previous Address: \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

SS# \_\_\_\_\_ Type of Work: \_\_\_\_\_

Spouse's/Guardian/Parent's Name: \_\_\_\_\_

Spouse's SS #: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

Who referred you to this office? (Name and address if doctor) \_\_\_\_\_

## Payment is due at time service is rendered:

**I plan to make payment of my medical expenses as follows:** (check one or more)

Cash / Check  Medicare  Master Card / Visa

**Please list your Insurance Carrier(s).** We file insurance for State Health Plan, Blue Cross and Blue Shield (BCBS), Medicare, and various HMO insurance plans. We do not file for any other insurance companies except for obstetrical and surgical patients. If you have other insurance, you may file yourself with the receipt given to you when you check out. Just attach this receipt to your insurance form and file.

Primary Insurance: \_\_\_\_\_ Cert#: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Cert#: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment thereof.

It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

Insurance payments are based on what insurance companies consider usual and customary. Oftentimes insurance payments are not 100% of fees charged. I understand that I am responsible for any copays, co-insurance and / or deductibles.

I authorize the release of any medical information necessary to process insurance claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_