Welcome To Our Office

PLEASE PRINT AND COMPLETE ALL PARTS

Central Obstetrics & Gynecology
Robert J. Wester, M.D.
Romy E. Mason, M.D.

Patient Number ________________________________ **Today's Date** ______________________

PATIENT NAME: (This section refers to PATIENT ONLY)

Name ____ Date of Birth ____/____/_____ SS # ______________________

Address ____________________________ Unit/Apt #________ City _________________ State ______ Zip __________

Home Phone ______________________ Cell _________________________ Work ______________________

Occupation ___________________________________ Employer ______________________________________

Spouse _____________________________ Employer _____________________ Phone _____________________

Relationship to Responsible Party ◻ Self ◻ Spouse ◻ Partner ◻ Daughter ◻ Other

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

◻ 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 __________________________________
Co-payment $ ______________________________

Secondary Insurance ___________________________
Claims Address _______________________________
City, State, Zip ________________________________
Phone ______________________________________
Primary Insured Person _________________________
ID/Policy # ___________________________________
Group # _____________________________________
Employer ____________________________________
Co-pay $ _____________________________________

NOTIFY IN EMERGENCY:

Name _________________________________ Relationship _______________ Phone ______________________

CONSENT FOR TEST RESULTS: I give Robert J. Wester, M.D. PC, and/or Romy E. Mason, M.D. 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.

Patient Name ____ Date _______________________

Signature ____ Relationship to patient: ◻ Self ◻ Parent ◻ Guardian