

**DOTHAN OBGYN, INC.**

1118 Ross Clark Circle

Suite 402

PATIENT NAME		First	Middle	Last
ADDRESS		City	State	Zip
PHONE HOME:		DATE OF BIRTH		ETHNIC GROUP (CIRCLE) ASIAN BLACK CAUCASIAN HISPANIC MIDDLE EAST UNDESIGNATED
Mobile: ( )				
MARITAL STATUS	AGE	SOCIAL SECURITY NUMBER		EMAIL (OPTIONAL)
EMPLOYER		EMPLOYER ADDRESS		EMPLOYER PHONE
<b>MEDICAL INSURANCE INFORMATION</b>				
COMPANY #1			POLICYHOLDER NAME	
POLICYHOLDER DATE OF BIRTH		POLICY NUMBER		GROUP NUMBER
COMPANY #2			POLICYHOLDER NAME	
POLICYHOLDER DATE OF BIRTH		POLICY NUMBER		GROUP NUMBER
MEDICAID NUMBER			MEDICARE NUMBER	
<b>RESPONSIBLE PARTY</b>				
<b>PLEASE COMPLETE THIS SECTION IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL</b>				
NAME		ADDRESS	CITY	STATE ZIP
PHONE HOME ( )		RELATIONSHIP		SOCIAL SECURITY NUMBER
MOBILE ( )				
<b>EMERGENCY CONTACT</b>				
NAME		RELATIONSHIP	PHONE NUMBER	
<b>REFERRAL INFORMATION</b>				
<b>HOW DID YOU HEAR ABOUT US?</b>				
TELEVISION	PHONE BOOK	NEWSPAPER	RADIO	WEBSITE
REFERRING PHYSICIAN NAME			FRIEND'S NAME	
OTHER				