Metro
Obstetrics & Gynecology
8391 Commerce Road, Suite 101
Commerce Twp., MI 48382
248-360-9090 • Fax 248-360-9093

PLEASE PRINT CLEARLY & COMPLETE ALL FIELDS

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Last 4 of Social Security: XXX-XX- _____ Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Ethnicity: [ ] Hispanic/Latino [ ] Non-Hispanic/Non-Latino [ ] Other

Race: [ ] Black/African American [ ] American Indian/Alaskan Native [ ] Asian [ ] Hispanic [ ] Native American
[ ] Native Hawaiian [ ] Other Pacific Islander [ ] White [ ] Other [ ] Declined to State

SPOUSE INFORMATION, IF APPLICABLE

Name: _____ Date of Birth: _____ Phone: _____

Employer: _____ Work Phone: _____

Please provide us with your email address ONLY if you would like to sign up for:
IQ Health - our secures online test result system

Email Address: _____

MEDICAL INSURANCE

Primary Insurance Company: _____ Subscriber's name (or "self"), _____ Birth Date: _____

Subscriber's Relationship to Patient: _____ ID#: _____ Group #: _____

Secondary Insurance Company: _____ Subscriber's name (or "self"), _____ Birth Date: _____

Subscriber's Relationship to Patient: _____ ID#: _____ Group #: _____

EMERGENCY CONTACT

Who would you like us to contact in case of emergency? _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC., THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee of $2.50 will be charged on all balances of 31 days and older. In the event of default, I agree to pay a collection cost calculated at 40% of my account balance and any reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date: _____ Your Signature: _____

Thank you for your careful completion of this form.