JACK W. TUBBS, JR., M.D.

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

DIANE LINK, RNC, NP
LASTENIA RYAN, MSN, WHNP-BC

Patient Information

Patient's Full Legal Name: _____
Last First MI Maiden

D.O.B.: ____/____/____ Age: _____ Allergies: _____

Patient's Address: _____

_____ _____ _____
City State Zip

Phone (H) _____ (W) _____ (C)_____

Social Security No: _____

Patient's Employer: _____ Occupation: _____

Marital Status: M S D W Student: FT___PT___ School: _____

Spouse/Parent Name: _____ Social Security No: _____

Employer: _____ Work Phone:_____

Emergency Contact:_____ Relationship:_____

Address:_____ Phone:_____

Referred By:_____ Primary Doctor:_____

Preferred Pharmacy: _____

Sex: _____ Race: _____ Ethnicity: _____ Preferred language:_____

Where did you here about Associates in OB/GYN:_____

Insurance Information

Primary Insurance: _____

Subscriber: _____ Birth Date:____/____/____

Policy#: _____ Group#: _____

Secondary Insurance: _____

Subscriber: _____ Birth Date: ____/____/____

Policy#: _____ Group#: _____

Medicaid Information

Medicaid Number: _____ Colorado Access: _____ PCP: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE THIS MEDICAL FACILTIY TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY SELF AND/OR MY DEPENDENTS, I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Date: ____/____/____ **Signature:** _____

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