MERCED OBGYN CARE, INC.
KRISTINA SOGOCIO, M.D.
360 E. Yosemite Avenue, Suite 300 · Merced, California 95340
Telephone: (209)723-6624 Fax: 877-682-6602

PATIENT INFORMATION FORM

PATIENT INFORMATION

Date_____/_____/_____ Home Phone_____Work Phone_____Cell Phone_____

Name _____ Social Security Number_____
Last Name First Name Middle Initial

Address _____ City _____ Zip _____

Age _____ D.O.B. _____/_____/_____ Single Married Widowed Separated Divorced

Email _____

Employer_____ Occupation _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account (if not the Patient)_____
Last Name First Name Middle Initial

Address(If different from Patient)_____ City _____ Zip _____

Phone _____ D.O.B. _____/_____/_____ Social Security Number _____

Employer_____ Occupation _____

Insurance Company _____

Subscriber ID/Member # _____ Group # _____

Is patient covered by additional insurance? ☐ **No** ☐ **Yes** **If yes, see reverse**.

ASSIGNMENT AND RELEASE

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT:
I hereby authorize the above named physician to release any information acquired in the course of my examination or treatment to the named insurance company for the purpose of billing. I also authorize release of information to my employer if this is a work related problem. I authorize payment directly to the above named physician of any medical benefits otherwise payable to me for his services described, but no to exceed the reasonable and customary charge for these services. It is understood that any monies received from the insurance company over and above any indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization. I further agree to pay all finance charges, collections cost (40%), Attorney fees, and any other cost that may be incurred to enforce collection of any amount.
I authorize the above named physician to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above named physician will verbally describe the nature of said procedures in lay terminology. Including possible complications and side effects and obtain verbal consent prior to procedures. I retain the right to refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications and side effects.

I UNDERSTAND THAT FAILURE TO PAY MY CO-PAY AT THE TIME OF SERVICE WILL RESULT IN AN ADDITIONAL ADMINISTRATIVE FEE.

_____ _____ _____
Signature Relationship to Patient Date

ADDITIONAL INSURANCE

Subscriber Name(If not the Patient) _____
Last Name First Name Middle Initial

Address(If different from Patient)_____ City _____ Zip _____

Phone _____ D.O.B. _____/_____/_____ Social Security Number _____

Employer_____ Occupation _____

Insurance Company _____

Subscriber ID/Member # _____ Group # _____