

# Queen Anne Obstetrics and Gynecology, PLLP

Susan M Petcoff, D.O. Lynne A Haspedis, D.O.

## Your information

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last Name First Name Middle Initial

Previous Last Names \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Single  Partnered  Married  Widowed  Separated  Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_

In case of emergency, whom should we notify? \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Spouse Partner Information

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

---

## Financial Responsibility / Assignment of Benefits

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. I authorize the Physician to release to my insurance company all information required for processing of my claim. I authorize my insurance benefits to be paid directly to the doctor. A service charge of 1.5% per month (18% annually) is charged on any balance over 60 days old with a \$0.50 minimum balance. Should my account be referred to a professional collection agency, the undersigned agrees to pay reasonable collection expense.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Please provide your insurance card for copy