

**Boojum Obstetrics & Gynecology**  
**655 S. Dobson Rd., Suite 101**  
**Chandler, AZ 85224**

PATIENT INFORMATION RECORD

Please print legibly and complete all boxes.

|  |         |                                 |                             |           |                    |                         |               |
|--|---------|---------------------------------|-----------------------------|-----------|--------------------|-------------------------|---------------|
| <input type="checkbox"/> New Patient                   |         | <input type="checkbox"/> Update |                             | Account # |                    | Today's Date            |               |
| PATIENT NAME   |         |                                 | GENDER                      |           | MARITAL STATUS     |                         | DATE OF BIRTH |
| (LAST)   | (FIRST) | (M I)                           | M                           | F         | M                  | W                       | DIV           |
| STREET ADDRESS   |         |                                 | CITY AND STATE              |           | ZIP CODE           |                         | HOME PHONE NO |
| MAILING ADDRESS  |         |                                 | CITY AND STATE              |           | ZIP CODE           |                         |               |
| PATIENTS EMPLOYER                                      |         |                                 | OCCUPATION                  |           | BUSINESS PHONE NO  |                         |               |
| EMPLOYER'S STREET ADDRESS                              |         |                                 | CITY AND STATE              |           | ZIP CODE           |                         |               |
| NAME / ADDRESS OF NEAREST RELATIVE NOT LIVING WITH YOU |         |                                 |                             |           |                    | RELATIONSHIP            |               |
| SPOUSE'S NAME OR RESPONSIBLE PARTY                     |         |                                 | ID/SS# of Responsible Party |           |                    | RELATIONSHIP TO PATIENT |               |
| SPOUSE'S EMPLOYER                                      |         |                                 | OCCUPATION                  |           | BUSINESS PHONE NO. |                         |               |
| EMPLOYER'S STREET ADDRESS                              |         |                                 | CITY AND STATE              |           | ZIP CODE           |                         |               |
| WHO REFERRED YOU TO THIS PRACTICE?                     |         |                                 |                             |           |                    |                         |               |
| PRIMARY INSURANCE - NAME AND ADDRESS                   |         |                                 |                             |           |                    | EFFECTIVE DATE          |               |
| NAME OF POLICY HOLDER                                  |         |                                 | POLICY OR ID #              |           | GROUP #            | OFFICE VISIT CO-PAY     |               |
| SECONDARY INSURANCE - NAME AND ADDRESS                 |         |                                 |                             |           |                    | EFFECTIVE DATE          |               |
| NAME OF POLICY HOLDER                                  |         |                                 | POLICY OR ID #              |           | GROUP              | OFFICE VISIT CO-PAY     |               |

In order to control our cost of billing, we request that the patient portion of office visits be paid at the time service is rendered. I agree to pay for all services rendered in accordance with the terms and conditions set forth in the office financial policy, of which I have received a copy.

"I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE (OR ANY OTHER INSURANCE COMPANY'S) BENEFITS BE MADE TO BOOJUM OBSTETRICS & GYNECOLOGY FOR SERVICES FURNISHED ME BY DR. DAVID N. KELLS OR HIS EMPLOYED NURSE PRACTITIONER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION, ITS AGENTS, OR ANY OTHER INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFIT'S PAYABLE FOR RELATED SERVICES."

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date Signed and Updated