OB-GYN Associates

101 Holbrook Street
Danville, VA 24541
Phone: (434) 792-7765
Fax: (434) 793-4061

PATIENT INFORMATION

Name:	Race/ Ethnicity:
Address:	Marital Status:
City:	Date of Birth:
State: Zip:	Social Security #:
Home Phone#:	Employer/School
Work Phone#:	Full -Time ____ Part-Time ____
Cell Phone#:	Employer Address:
Email Address:	
Emergency Contact: Relationship:	Phone #:

PARENT OR SPOUSE INFORMATION

Name:	Date of Birth:
Address:	Social Security#:
	Full-Time_____ Part-Time___
City:	Employer:
State: Zip:	Employer Address:
Home Phone #:	
Cell Phone #:	Work Phone#:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID#:	ID#:
Group Number:	Group Number:
Group Name :	Group Name:
Address:	Address:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth: Relationship to Patient	Subscriber Date of Birth: Relationship to Patient:

This is an agreement between OB-GYN Associates of Danville and the responsible party:

Late Policy: All efforts are made to keep our physicians schedule on time; therefore, if you are more than 15 minutes late, every effort will be made to fit you into the schedule; however, there is no guarantee that you will be seen. If the providers' schedule is full you will be asked to reschedule your appointment.

Co-Payment: All co-payments are required at the time of service you maybe asked to reschedule your appointment if you do not pay your co-payment.

Payment options if you do not have proof of insurance or have no insurance: You are responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and by approval of our billing department, you may pay 50% on the date of service and the balance in 30 days.

Payments: Unless other arrangements are approved by the billing department, the balance on your statement is due on the due date posted on your statement. If your account becomes past due, you agree to pay all collection and court fees that are incurred.

Returned Checks: There is a $35.00 fee for any checks returned by the bank.

Signature:_____ Date:_____

Patient or Parent of Minor