NEW BEGINNINGS OB/GYN, PA
336 N. BABCOCK ST. STE 101
MELBOURNE, FL 32935
PHONE (321)775-1470
FAX (321)775-1480

## DEMOGRAPHICS

Name: ______________________________ Date of Birth: ____/____/____ AGE:____
Street Address: ______________________________
City: ____________________ State: ____________________ Zip: __________
Home Phone #: ( ) ____________________ Cellular Phone :( ) ____________________
Social Security Number: ______________________________
**E-mail:** ____________________ Marital Status: __Single __Married __Divorced __Widowed
Smoker:____YES_____NO Alcohol:___NO____YES
Employer: ______________________________ Occupation: ____________________
Work Phone: ____________________ Extension:________
Spouse/significant other: ____________________ Phone :( ) ____________________
Emergency contact: ____________________ Phone :( ) ____________________
Referred to practice by: ______________________________
Primary Care Provider: ____________________ Phone :( ) __________ Fax :( ) __________
Pharmacy: ______________________________ Phone :( ) ____________________
Primary Language Spoken: ____________________ DO you have a living will? __________

## INSURANCE INFORMATION

Primary: ______________________________
ID#: ______________________________
Group#: ______________________________
Claims Address: ______________________________
______________________________
Subscriber: Spouse Self Dependent
Name of subscriber: ____________________
Subscriber's SSN/ DOB: ____________________

Secondary ______________________________
ID#: ______________________________
Group #: ______________________________
Claims Address: ______________________________
______________________________
Subscriber: Spouse Self Dependent
Name of subscriber: ____________________
Subscriber's SSN/DOB: ____________________

**AUTHORIZATION TO PAY BENEFITS TO PHYSICAIN:** I hereby authorize payment directly to the physician for the surgical and/or medical benefits, if any, otherwise payable to me for her services as described. Realizing I am responsible to pay non covered services. If I have more than one insurance and I do not disclose that information I am responsible for payment of all rendered services.

SIGNATURE: ______________________________ DATE: ______________________________

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize New Beginnings OB/GYN to release information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE: ______________________________ DATE: ______________________________