Khan Obstetrics & Gynecology Associates, P.A.

1113 S. State Street
Dover, DE 19901
Phone: (302) 735-8720
Fax: (302 735-8724

PATIENT INFORMATION

Name: _____
(Last Name) (First Name) (Middle Initial)
Address: _____
City, State, Zip Code: _____
Social Security #: _____ Date of Birth: _____ Marital Status: _____
Home Telephone: _____ Business Telephone: _____
Name of Employer: _____
Address: _____

In case of emergency, who should be notified?: _____
(Name) (Tel #) (Relationship)

Primary Health Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ Relationship: _____
Place of Employment: _____

Secondary Health Insurance: _____
Policy Number: _____ Group Number: _____
Policy Holder Name: _____ Relationship: _____
Place of Employment: _____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with _____,
(Insurance Company Name)
and assign directly to KHAN OB/GYN all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relation to Patient Date