Andrew A. Roth M.D., S.C.
OBSTETRICS AND GYNECOLOGY

ANDREW A. ROTH, M.D., F.A.C.O.G
JANYCE AGRUSS, DNSC. APN/CNP

NAME_____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

PHONE: HM_____**CELL**_____**WK**_____

PATIENT SSN_____**PATIENT DOB**_____

EMAIL ADDRESS_____

REFERRED BY_____**EMERGENCY CONTACT**_____

PHONE_____**RELATION TO PATIENT**_____

INSURANCE COMPANY_____

PRIMARY POLICY HOLDER_____

PRIMARY POLICY HOLDER'S DATE OF BIRTH_____

PRIMARY POLICY HOLDER'S SS# _____-----_____ ----- _____

PRIMARY POLICY HOLDER'S EMPLOYER_____

ADDRESS_____

PHONE#_____

IF SELF EMPLOYED: COMPANY NAME_____

ADDRESS/PHONE #_____

PHARMACY NAME_____**PHONE #**_____

PHARMACY ADDRESS_____

******I UNDERSTAND ONCE MY BILL IS SUBMITTED TO MY INSURANCE COMPANY, NO CHANGES CAN BE MADE. PLEASE INFORM YOUR PHYSICIAN OF ANY SPECIAL CIRCUMSTANCE'S WITH THE DIAGNOSIS AT THE TIME OF YOUR VISIT.**

I UNDERSTAND IF MY ACCOUNT GOES TO A COLLECTION AGENCY FOR NON-PAYMENT, A COLLECTION AGENCY FEE OF 33.33% WILL BE ADDED TO MY BALANCE.

****I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM ALL INSURANCE CLAIMS TO BE MADE DIRECTLY TO ANDREW A. ROTH M.D.,S.C.**

DATE_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON