



# OB/GYN Specialists of Brevard

Edwin B. Hayes, M.D.

Obstetrics and Gynecology

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[www.obgyspecialistsofbrevard.com](http://www.obgyspecialistsofbrevard.com)



## PATIENT REGISTRATION

PATIENT		INSURED PARTY	
Last Name		Last Name	
First Name		First Name	
Street		Street	
City		City	
State	Zip	State	Zip
E-mail		E-mail	
Hm Phone	(      )	Hm Phone	(      )
Wk Phone	(      )	Wk Phone	(      )
Cell Phone	(      )	Cell Phone	(      )
Date of Birth		Date of Birth	
SSN		SSN	
Employer		Employer	
Status	<input type="checkbox"/> Single <input type="checkbox"/> _____ <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Insured's Relationship to Patient	

IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

EMERGENCY CONTACT HM PHONE (      ) \_\_\_\_\_

CELL PHONE (      ) \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

PHYSICIAN PHONE (      ) \_\_\_\_\_

PLEASE SUBMIT INSURANCE CARDS AND PHOTO IDENTIFICATION FOR COPYING

CONSENT FOR TREATMENT: The undersigned authorizes Dr. Edwin B. Hayes, M.D. to provide treatment including X-rays, blood withdrawal, local anesthesia, intravenous solutions and the performance of other procedures which the Provider considers necessary and proper in the treatment of the above named patient.

RELEASE OF RECORDS: I hereby authorize the Provider to furnish insurance companies with any information concerning my treatment which may be requested, including photocopies from my patient records as necessary for completion of my claim or as may be required by law. I further authorize the Provider to furnish information from my records pertaining to the treatment as requested by other Doctors or medical facilities for continued care and treatment. I am aware that this authorization may be revoked by me at any time.

PAYMENT AGREEMENT: I, the undersigned, understand that I am responsible for all charges for treatment received regardless of insurance coverage. I understand that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. Provider reserves the right to decline further services to the patient for non-payment. Patient accounts are due at the time treatment is given unless other arrangements are made in advance. A charge of \$30.00 will be charged on all RETURNED CHECKS. We do not overbook our patients therefore we require our patients to pay a \$30.00 missed appointment fee. Three no shows/ or missed appointments will result in dismissal from our practice. You must call 24 hours in advance to cancel or switch an appointment. All co-payments and fees for services will be due at time of service. Failure to provide payment will result in a \$ 5.00 processing fee. PAYMENT PLANS that require additional billing will acquire a \$5.00 processing fee per bill.

I, the undersigned, assign benefits payable for physician services to the physician or organization furnishing the services and authorize the physicians group or organization to submit a claim to my health insurance carrier on my behalf.

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR PARENT, IF A MINOR)

DATE \_\_\_\_\_