Manatee Gynecology, LLC

P: 941-792-4993 | F: 941-795-2905

Patient Information

Failure to disclose accurate information may result in the termination of your relationship with our physicians/office.

Patient Name (Last, First, M.I., Maiden) _______ Date of Birth _______ Social Security Number _______

Marital Status: ❏ Single ❏ Married ❏ Divorced ❏ Widowed ❏ Separated ❏ Partner

Race/Ethnicity: ❏ Asian ❏ Black/African ❏ Caucasian ❏ Hispanic/Latino ❏ Native American ❏ Pacific Islander ❏ Prefer Not to Answer ❏ Other:_______________________________________

Mailing Address (House Number, Street, City, State, Zip Code) _______

Home Phone _______ Mobile Phone _______ Work Phone _______ Email _______

Spouse or Guardian (If Minor) _______

Emergency Contact Person _______ Relationship _______ Phone _______

Primary Insurance Company _______ Secondary Insurance Company _______

Identification Number _______ Identification Number _______

Policy Holder _______ Policy Holder _______

Date of Birth _______ Social Security Number _______ Date of Birth _______ Social Security Number _______

Have you ever applied or been approved for any type of MEDICAID ASSISTANCE? ❏ Yes ❏ No

Who is your referring physician? ____

If you are covered by an HMO/PPO requiring an authorization, it is your responsibility to obtain that authorization prior to your scheduled appointment. If you have any questions about authorizations, call your insurance carrier, member services department, or if applicable, your primary care physician. Depending on the type of service you need, you may be required to make a deposit of payment agreement for the estimated charges prior to being seen. **A service charge of $15.00 will be added to your account if your estimated portion is not collected at the time of service.**

I hereby authorize Manatee gynecology, LLC to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services to myself or dependents. I understand that I am responsible for any amount not covered or authorized by my insurance carrier for all office or surgical charges. Any unpaid balance older than 90 days will be sent to a third-party collection agency and you will be billed a $50.00 service fee.

Please indicate if you have ever seen any of the following providers in the office or in the hospital:

❏ Dr. Marion Pandiscio ❏ Dr. Kinnari Desai ❏ Dr. Lee Biggs ❏ Linda O'Gara, WHNP ❏ Joyce Kepto, CNM, APRN

❏ Sammie Billman, DNP, APRN ❏ Kaleigh Braden, DNP, APRN ❏ Felicia Montanez, APRN

Signature of Patient/Guardian _______________________ Date _______________________