Charles A. Safely, M.D., F.A.C.O.G
Obstetrics & Gynecology, Board Certified: OB/GYN
Phone# (817) 284-1496 Fax# (817) 284-3923

PLEASE PRINT CLEARLY Family Physician: Referring Physician:

Patient Information: Marital Status: Married Divorced Single Widowed (Please Circle)

Student Status: Full Time Part Time None

Patient Information:

Patient Name:____________________________Date of Birth:_______________Social Security Number:_____________

Home Address:___________________________Apt #:_______City:_________________State:________Zip Code:______

Home Phone Number:____________________Cell Phone Number:______________E-Mail_________________________

Employer Name:_________________________________Work Phone Number:_________________

Please complete entire insurance section below

Policy holder's insurance information: (If different from patient)

Policy holder's name:_______________________Date of Birth:_________Social Security Number:_________________

Home Address:___________________________Apt #:_______City:_________________State:________Zip Code:______

Home Phone Number:____________________Cell Phone Number:______________

Employer Name:_________________________________Work Phone Number:_________________

Primary Insurance Information:

Policy holder's Name:______________________Date of birth:____________Social Security#____________________

Name of insurance company:___________________________________Phone Number:___________________________

Policy Number:________________________________Group Number:________________

Who is the insured? Patient:_______ Other:_________Relationship to patient:_______________

Secondary Insurance Information:

Policy holder's Name:_____________________Date of birth:___________Social Security#_____________

Name of insurance company:__________________________________Phone Number:______________________

Policy Number:_______________________________Group Number:_______________

Who is the insured? Patient:______ Other:________Relationship to patient:_________________

Emergency notification:
Name:________________________Home#________________Cell#_____________Relationship to patient:________

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Authorization for Payment, Release of Information and Treatment:

I hereby authorize payment to Charles A. Safely, M.D. of any medical or surgical benefits; this will remain in force until I revoke this authorization in writing. I also understand that I am ultimately responsible for medical expenses or services not covered by my insurance. I authorize Charles A. Safely, M.D. to release medical records, including HIV testing and/or drug abuse testing information, as requested by representatives of insurance companies or other related organizations for payment of claims. You agree if account goes to collections, you will be responsible for all added/additional penalties and/or attorney's fees. I also consent to office procedures and medical treatments unless these are specifically refused or declined.

Patient and/or Guardian Signature ____Date________________

I hereby authorize Charles A. Safely, M.D. and/or staff to leave my normal test results on my answering machine or voice mail.

Yes___No____Patient and/or Guardian Signature_____________________________________Date____________

FOR FUTURE USE ONLY

Three Year Update Form-The information above has not changed

Updated: Signature:____Date:_______________________

Signature:____Date:_______________________