Scott M. Gulinson, MD, PC
Board Certified Women's Health Care Services
Fellow, American College of OB/GYN Physicians
OBSTERICS, GYNECOLOGY, INFERTILITY and
ULTRASONOGRAPHY

5310 W. Thunderbird Road
Suite 308
Glendale, Arizona 85306

Office: 623-412-2229
Fax: 602-314-5843

Patient Information

Date:_____
Patient Name:_____
(Last) (First) (Middle)
SS#_____DOB:_____Age:_____
Mailing
Address:_____ City:_____ State :_____Zip:_____
Home Ph#:_____ Cell Ph#_____ Work Ph#_____
E-Mail_____ May we contact you: Yes No
Marital Status: *Single* *Marries* *Divorced* *Widow*
Primary Care Physician: _____ Phone: _____
Whom may we thank for referring you to our office? _____
Emergency
Contact: _____ Relationship:_____ Phone:_____

Please complete if Patient is a Minor
Responsible Party:_____ Relation to Patient:_____
Address:_____ City:_____ State :_____Zip:_____
SS#_____ Hm Ph#:_____ WK Ph#_____
Do we have permission to treat minor children in your absence? Yes___ No___ Signature:_____

INSURANCE INFORMATION
PRIMARY Relation to
Insurance:_____ Policy Holder:_____ DOB:_____ Patient:_____
Ins Ph:_____ Policy Holder Employer:_____Wk#_____
Policy Holder SS#_____ Policy ID#:_____ GR#:_____
Address:_____City:_____State_____Zip:_____
Secondary Insurance
Insurance:_____ Policy Holder:_____ DOB:_____ Rel. to Pt. _____
Ins. PH#:_____Policy Holder Employer: _____ Wk#_____
Policy Holder SS# _____ Policy ID#: _____ GR#_____
Address:_____City:_____State_____Zip:_____

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ASSIGMENT AND RELEASE:

I hereby agree to accept financial responsibility for all charges uncured in the course of my treatment. In the case of Medicare or other insurance that the physicians have executed an agreement with, I understand that I am responsible for paying any deductibles or co-payments required under the terms of my insurance plan. Fees are $25.00 - $ 50.00 for cancelled appointments for less than a 24 hour notice. Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees. I hereby authorize the physicians at Scott. M. Gulinson MD to bill Medicare and/or my health insurance plan. I hereby authorize the release of information acquired in the course of the examination and treatment, should it become necessary to secure payment of benefits.

Signature of Patient or Responsible Party:_____Date_____

Power of Attorney: _____Date:_____

Update Employee In: _____Date:_____