Center for Advanced Gyn & Urogynecology
Shobha Sikka M.D. FACOG
5530 Wisconsin Avenue Suite 914, Chevy Chase MD 20815

PATIENT PROFILE

Please print and complete ALL sections below!

Today's Date:______________________________

Name:____ Is this your legal name? ❑YES ❑NO
(First) (M.I) (Last)

If not, what is your legal name? ____________________ Former Name: ____________________DOB: __________

Home Address: ____
(Street) (Apt. #) (City) (State) (Zip Code)

SS#:____________________ Marital Status: S M Sep W D Spouse/ Significant other:____________________

Employer:______________________________Occupation:______________________________

Home Phone: (______) __________Cell Phone: (______) ______________Business Phone: (_____)__________________

Best number to call: (______) ________________May we leave a message? ❑YES ❑NO

Primary Care Doctor (PCP): ________________________________Phone#: (________) ____________________

OBGYN:______________________________________Phone#: (_________)______________________

Pharmacy Name: ____

Pharmacy Address: ____

Phone#: (_________) ___________________________ Email Address: ______________________________

May we use your email to leave you confidential, personal, HIPPA protected information? ❑YES ❑NO

If available, would you prefer to receive appointment reminders by Email? ❑YES ❑NO

How did you hear about our office? ❑ Web site ❑Radio ❑Newsletter ❑Friend ❑ Other______________________________

GUARANTOR INFORMATION: (Person responsible for payment, if other than self or if patient is a minor)

Person Responsible for Account: ______________________________Relationship: ____________________
(Last) (First)

Address: ____
(Street) (City) (State) (Zip Code)

Home Phone: (______)________________Work Phone: (_________)______________Cell: (_____)____________________

INSURANCE CARRIER INFORMATION:

Primary Insurance: ____________________________Eff. Date: __________Policy #: ____________________

Billing Address: ____

Insured Name: ______________________________DOB: ______________Relationship: ____________________

Secondary Insurance: ____

Insured Name: ______________________________DOB: ______________Relationship: ____________________

EMERGENCY CONTACT:

Name: ____ Relationship: ______________________________

Home Phone: (____)____________________ Cell Phone: (_____)______________________ Work: (_________)________________

PLEASE BE ADVISED THAT YOU MAY RECEIVE SEPARATE BILLS FROM OTHER ORGANIZATIONS FOR ANY LAB TESTS, PAP SMEARS, CULTURES, BIOPSIES AND RADIOLOGY PROCEDURES, AS THEY ARE PERFORMED BY AN OUTSIDE PROVIDER.

Financial Responsibility, Authorization & Consent

I authorize the assignment of insurance benefits to Center of Advanced Gyn & Urogynecology and understand and acknowledge that I am financially responsible for all services rendered to me whether or not they are covered by insurance. For those insurance plans where the practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. This assignment will remain in effect until revoked in writing.

I acknowledge that my account must be kept current and any past due balances are due prior to my next visit. Failure to pay outstanding balances may result in the rescheduling of an appointment. Co-pays and deductibles will be collected at the time services are rendered. I certify that the above information provided by me is correct. I further agree that a photo copy of this agreement shall be as valid as the original. Please be advised there may be an additional charge if any separate issues outside of the normal well woman annual exam are discussed.

If you are unable to keep your scheduled appointment, please notify our office as soon as possible. Failure to give 24 hours notice of a cancellation for an appointment or no-showing of an appointment may result in a charge of $50 on your account.

I agree to notify Center of Advanced Gyn & Urogynecology of a change in my address, guarantor, insurance status, or in my ability to pay for services provided to me as soon as possible.

I consent to the use and disclosure of my confidential health information for the purposes of treatment, payment, and/or practice operations. This consent will remain in effect until revoked in writing.

Signature of Responsible Party: ____ Date: ____________________