Midwest Perinatal Associates, P.A.
12200 West 106th Street
Overland Park, KS 66215
913-599-1396

Tracy A. Cowles, M.D.
Brent E. Finley, M.D.
Louis E. Ridgway, M.D.

PATIENT REGISTRATION INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

Please complete all sections and provide us with your medical insurance coverage information.

Name ______________________________ SS# ______________
Last First MI

Home Address ______________________________
City State ZIP Code

Home Telephone ______________ Cell Telephone ______________

Work Telephone ______________

Employer ______________ Occupation ______________

Employment address ______________________________

Birth Date ______________ Age ________ Marital Status ________ ALLERGIES:
Soaps ______ Latex ______
Email: ______________________________ Other ______

SPOUSE/SIGNIFICANT OTHER OR PARENT INFORMATION (**MUST HAVE POLICY HOLDER'S INFO PRIOR TO FILING CLAIM**)

Name ______________________________ SS# ______________
Last First MI

Home Address ______________________________
City State ZIP Code

Home Telephone ______________ Employer ______________

Birth Date ______________ Age ________ Employment Telephone ______________

EMERGENCY CONTACT INFORMATION

Name of a person not living with you ______________ Relationship ______________

Home Address ______________________________
City State ZIP Code

Home Telephone ______________ Employment Telephone ______________

INSURANCE INFORMATION

Policy Holder (circle one) Self Spouse Parent

Primary Insurance ______________ Policy # ______________

Through (Employer) ______________ Group # ______________

Claim mailing address ______________________________
City State ZIP Code

Secondary Insurance ______________ Policy # ______________

Through (Employer) ______________ Group # ______________

Claim mailing address ______________________________
City State ZIP Code

________ NO INSURANCE (Payment is expected at the time of service unless previous arrangements were made.)

I hereby give lifetime authorization for payment of insurance benefits to be made directly in Midwest Perinatal Associates, P.A. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure payments of benefits. I agree that a photocopy of this agreement shall be as valid as the original.

Date ______________ Patient signature ______________________________