

Women's Health Associates, P.C.

Date _____

PATIENT INFORMATION (Please Print)					REFERRED BY
PATIENT NAME First Middle Last					<i>PLEASE CHECK THE NUMBER AT WHICH WE MAY LEAVE A DETAILED MESSAGE.</i>
SEX [] Male [] Female	DATE OF BIRTH	AGE	MARITAL STATUS [] Life Partner [] M [] S [] W [] D	SOCIAL SECURITY NUMBER	
ADDRESS Street City State Zip					HOME PHONE NO. () []
ARE YOU [] Employed [] Full-Time Student [] Part-Time Student			OCCUPATION OR, IF STUDENT, GRADE		DRIVER'S LICENSE St. #
EMPLOYER OR SCHOOL NAME & ADDRESS					WORK OR SCHOOL PHONE NO. () []
E-MAIL ADDRESS					CELL PHONE NO. () []
					PHARMACY PHONE NO. ()

PERSON FINANCIALLY RESPONSIBLE (if different from above)			
NAME		PATIENT'S RELATIONSHIP TO INSURED [] Self [] Spouse [] Child [] Other_____	OCCUPATION
ADDRESS Street		SOCIAL SECURITY NUMBER	HOME PHONE NO. ()
City	State	Zip	EMPLOYER NAME
			EMPLOYER PHONE NO. ()

PRIMARY INSURANCE If no insurance please check []			
INSURANCE COMPANY		INSURED (if other than patient please complete)	
INSURANCE COMPANY NAME OR MEDICARE INFORMATION		POLICY IN NAME OF (insured)	
POLICY/ID NUMBER	GROUP NUMBER	INSURED'S ADDRESS Street	
INSURANCE COMPANY ADDRESS Street		City	State Zip
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED [] Self [] Spouse [] Child [] Other_____
INSURANCE COMPANY PHONE NUMBERS Verifying: () Claim: ()		DATE OF BIRTH	SEX [] Male [] Female
		EMPLOYER'S NAME & PHONE NO.	SOCIAL SECURITY NUMBER

SECONDARY INSURANCE			
INSURANCE COMPANY		INSURED (if other than patient please complete)	
INSURANCE COMPANY NAME OR MEDICARE INFORMATION		POLICY IN NAME OF (insured)	
POLICY/ID NUMBER	GROUP NUMBER	INSURED'S ADDRESS Street	
INSURANCE COMPANY ADDRESS Street		City	State Zip
City	State	Zip	PATIENT'S RELATIONSHIP TO INSURED [] Self [] Spouse [] Child [] Other_____
INSURANCE COMPANY PHONE NUMBERS Verifying: () Claim: ()		DATE OF BIRTH	SEX [] Male [] Female
		EMPLOYER'S NAME & PHONE NO.	SOCIAL SECURITY NUMBER

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NO. ()
FAMILY DOCTOR		PHONE NO. ()

If patient is under 18 years of age, please complete the following:		
ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Women's Health Associate's, P.C. to release medical information that may be necessary to request claim reimbursement from my insurance company to whom claims have been submitted.

I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payments to be made payable to Women's Health Associates, P.C. directly and I understand that any overpayment will be refunded to me from the doctor's office.

I understand that I will be responsible for any unpaid balance. I further understand that, if I have an insurance with which Women's Health Associates, P.C. participates, I will be responsible for any unpaid balance remaining after 45 days.

I understand that if any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this balance, I will be responsible for all attorney, court costs and collection agency fees.

Signature _____ Date _____
(insured or authorized person)