Patient Information

Date _____ /_____ /_____ Pharmacy Name _____ Phone _____ - _____ - _____

Patient's Name _____ Social Security # _____ - _____ - _____

DOB _____ /_____ /_____ Address _____ City _____ ST _____ Zip _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Email Address _____

Patient's Employer _____ Occupation _____

Employer's Address _____ City _____ ST _____ Zip _____

Spouse/Guardian's Name _____ DOB _____ /_____ /_____ Social Security # _____ - _____ - _____

Spouse/Guardian's Employer _____ Occupation _____ Work Phone _____ - _____ - _____

RESPONSIBLE PARTY / GUARANTOR FOR SERVICES

Name _____ Relationship _____

Address _____ Social Security # _____ - _____ - _____

Employer _____ Daytime Phone _____ - _____ - _____

Guarantor Signature _____

INSURANCE INFORMATION

Primary Insurance Company _____ Network _____

Insurance Company Address _____ City _____ ST _____ Zip _____

Policy/ID# _____ Group# _____

Name of Policy Holder _____ DOB _____ /_____ /_____ Social Security # _____ - _____ - _____

Relationship _____

Secondary Insurance Company _____ Network _____

Insurance Company Address _____ City _____ ST _____ Zip _____

Policy/ID# _____ Group# _____

Name of Policy Holder _____ DOB _____ /_____ /_____ Social Security # _____ - _____ - _____

Relationship _____

Emergency Contact _____ Phone _____ - _____ - _____ Relationship _____

PATIENT AUTHORIZATION

As a courtesy to our patients, Women's Medical Associates will file your insurance. I hereby authorize Women's Medical Associates to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits to include Medicare benefits directly to Women's Medical Associates. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I understand that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature _____ Date _____ /_____ /_____

Women's Medical Associates of Nashville
AdvancedHEALTH

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