PATIENT INFORMATION
(Please Print)

Date_____ Referred By_____

Patient's Name_____Social Security # _____

DOB____/___/____Address_____City_____ST_____Zip_____

Home Phone #_____Work Phone #_____

Cell Phone # _____ E-mail Address_____

Patient's Employer_____Occupation_____

Employer's Address_____City_____ST_____Zip_____

Spouse/Guardian's Name_____DOB___/___/___Social Security # _____

Spouse/Guardian's Employer_____Occupation_____Bus. Phone #_____

Responsible Party/Guarantor for Services

Name_____Relationship_____

Address_____Social Security # _____

Employer_____Daytime Phone #_____

Guarantor Signature _____

Insurance Information

Primary Insurance Company_____HMO____PPO____Other_____

Ins. Co. Address_____City_____ST_____Zip_____

Policy/ID #_____Group #_____Plan #_____

Name of Policy Holder_____Date of Birth_____Social Security # _____

Relationship_____

Secondary Insurance Company_____HMO____PPO____Other_____

Ins. Co. Address_____City_____ST_____Zip_____

Policy/ID #_____Group #_____Plan #_____

Name of Policy Holder_____Date of Birth_____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 I understand that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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_____