Women's Health Specialties – North

Patient Information

Provider: _____ Appointment Date: _____

We will need a copy of all insurance cards listed below. In the event any information provided today should change, please contact our office so that we may update your account.

Patient Information:

Name:_____

Address:_____

City:_____

State:_____Zip Code:_____

DOB:_____ Age:_____

SS#:_____

Gender: Male Female (PLEASE CIRCLE)

Marital Status: Single/Married/Other

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Employer: _____

Employer Phone #: _____

Partner's Name:_____

DOB:_____ Age:_____

SS#:_____

Employer:_____

Employer Phone #:_____

Reason for visit:_____

If patient is under the age of eighteen, who will be the party responsible?:

Name:_____

Address:_____

City/State/Zip code:_____

DOB: _____ SS#:_____

Relationship to Patient: _____

Insurance Information:

Primary Insurance Co: _____

ID#:_____ Grp#:_____

Insurance Benefits Phone #:_____

Insured's Name:_____

Secondary Insurance Co:_____

ID#:_____ Grp#:_____

Insurance Benefits Phone #:_____

Insured's Name:_____

Physician Information:

Primary Care Physician:_____

Authorization #:_____

Referring Physician:_____

Referring Physician Phone #:_____

Referring Physician Address_____

Pharmacy Information:

Preferred Pharmacy_____

Pharmacy Phone #:_____

Records Requested: Yes No (PLEASE CIRCLE)

Person To Contact In Case Of An Emergency:

Name:_____

Address:_____

City/State/Zip:_____

DOB:_____ SS#:_____

Home Phone #: _____

New Packet Information Sent: Yes No (PLEASE CIRCLE) Date: _____

I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). 2. I authorize my insurance carrier to release information regarding my coverage to Women's Health Specialties. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, accreditation agency, or any physician/insurance carrier(s) needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Women's Health Specialties. 3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Women's Health Specialties. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services rendered by my dependent or me. In the event my insurance does not accept Assignment of Benefits, or if payments are made directly to my representative, or me I will insure such payment to Women's Health Specialties.

Signature: _____Relationship: _____ Date: _____