WOMEN'S MEDICAL CENTER PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

DATE: _____

Patient Legal Name _____

If Minor, Parent or Legal Guardian Name _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Birth Date** _____

Cellular Phone _____ **Social Security #** _____

Message Phone _____ **Referred by** _____

Patient employed by _____ **Occupation** _____

Business Phone _____ **Are calls allowed?** ☐ **Yes** ☐ **No**

Emergency Contact (not at same number) _____ **Phone** _____

Marital Status ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Race ☐ **American Indian** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **White** ☐ **Other**

Ethnicity ☐ **Hispanic or Latino** ☐ **Non Hispanic or Latino** **Primary language** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

SECONDARY INSURANCE **Name of Insurance Company:** _____

Address of Insurance Company _____

Insurance Number _____ **Group #** _____

Name of Policy Holder AND relationship to you _____

Home Phone _____ **Birth Date** _____ **Social Security #** _____

Employed by: _____ **Business Phone** _____

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

If no, would you like information on it? ☐ **Yes** ☐ **No**

AUTHORIZATION OF CARE

Authorization is given to Women's Medical Center, its providers and employees to provide services and administer provider orders. Certain procedures require a separate consent form.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the physician/provider for services. Failure to pay any balance due by the undersigned may involve a collection agency or attorney. It is understood and agreed that reasonable attorney fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, agrees to pay all charges not paid in full to Women's Medical Center by a third-party payer.

_____ _____

Patient signature AND legal guardian signature (if patient is a minor) **Date**