

PATIENT INFORMATION

PLEASE PRINT

Patient Information

Name: _____ Date of Birth: _____ Age: _____ Are you a new patient? Yes No
Address: _____ City: _____ State: _____ Zip Code: _____
Race:* _____ Ethnicity:* _____ Primary Language:* _____ *Required by Healthcare/Meaningful Use Legislation
Email address: _____ Preferred Pharmacy: _____ Location: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____

Patient is: _____ Is the patient a student? Yes No
 Single Married Separated Divorced Widowed If yes, Full-Time Part-time

Patient's Employer: _____ Insurance through patient's employment? Yes No
If yes, Insurance Co. Name: _____ Policy # _____ Group # _____ Plan Code _____
Is the patient on Medicare? Yes No Is the patient on Medicaid?
If yes, Medicare No. _____ If yes, Medicaid No. _____
Primary Care Physician: _____ Address: _____

Husband/Partner Information

Name: _____ Date of Birth: _____ Social Security No. _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Insurance through spouse/partner? Yes No
If yes, Insurance Co. Name: _____ Policy # _____ Group # _____ Plan Code _____

Parent/Guardian Information

Father:

Name: _____ Date of Birth: _____ Social Security No. _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Mother:

Name: _____ Date of Birth: _____ Social Security No. _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Please sign below so that our office may complete your insurance claims. THANK YOU.

I authorize Women's Care Inc. to release all information necessary to process an insurance claim.

I authorize payment of medical and/or surgical benefits to Women's Care Inc. (including Medicare, other government sponsored programs, private insurance and any other health insurance plan). I understand that I am financially responsible for medical charges, whether or not paid by my insurance.

Women's Care Inc. is not responsible for any claimed errors in payment not exceeding the actual charge.

The resolution of any such matter is solely between the insurer and the patient or subscriber.

This authorization will remain in effect until revoked in writing. A photocopy of this authorization is to be considered as valid as an original.

Patient Signature: _____ Date: _____