**PARTNERS IN WOMEN'S HEALTHCARE, PC**
**PATIENT INFORMATION *(please print)***

Patient Name:_____Birthdate:_____Marital Status:_____

Address:_____City:_____State: _____ Zip: _____

Home Phone#_____Cell#_____Work#_____

Social Security #:_____Email Address_____

Employer:_____Occupation:_____

**If Minor,** Parent/Guardian Name:_____Home Phone:_____
Parent/Guardian Address:_____ Work Phone: _____

Spouse's Name:_____Birthdate:_____Social Security#_____
Spouse's Work Phone:_____Employer:_____Occupation:_____

Emergency contact:_____
Relationship to you:_____Phone:_____

Doctor Who Referred You: _____ Phone: _____
Family Physician Name:_____Phone:_____
How did you learn of Partners in Women's Healthcare? _____

Pharmacy Name/Location:_____
Mail Order Pharmacy Name:_____

**PAYMENT POLICY**: Payment for office visits is expected at the time of service. If we have a participation agreement with your insurance company, we will submit the claim to your insurance. You will be required to pay any co-payment the same day the service is rendered. Any additional deductible, co-insurance or non-covered services are the patient's financial responsibility.

**INSURANCE INFORMATION:**
**Primary Insurance Company:**_____ID#:_____

Subscriber's Name:_____Group#:_____

Subscriber's Relationship to Patient:_____Subscriber's Birthdate:_____

Subscriber's Employer:_____

**Secondary Insurance Company:**_____ID#:_____

Subscribers's Name:_____Group#:_____

Subscriber's Relationship to Patient:_____Subscriber's Birthdate:_____

Subscriber's Employer:_____

**RELEASE & ASSIGNMENT:** I hereby consent to any necessary medical diagnosis and treatment for myself, child, or above-named individual for whom I am legally responsible. I authorize the release of medical information to my insurance carrier/s to determine benefits payable for services rendered as well as direct payment to Partners in Women's Healthcare. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

_____ _____

**Patient Signature/Personal Representative** **Date**