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

Patient Name: _____Birthdate: _____Marital Status: _____

Address: _____City: _____State: _____ Zip: _____

Home Phone#_____Cell#_____Work#_____

Email Address_____

Employer: _____Occupation: _____

If Minor - Parent/Guardian Name: _____Home Phone: _____
Parent/Guardian Address: _____Work Phone: _____

Spouse's Name: _____Birthdate: _____Occupation: _____
Employer: _____Work Phone: _____
Is Spouse Emergency Contact? Yes____ No____ Emergency Contact Phone #: _____
Name of Emergency Contact If Other Than Spouse: _____
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#: _____
If Tricare Insurance - Subscriber's Social Security #: _____
Subscriber's Relationship to Patient: _____Subscriber's Birthdate: _____

Subscriber's Employer: _____

Secondary Insurance Company: _____ID#: _____

Subscriber's Name: _____Group#: _____
If Tricare Insurance - Subscriber's Social Security #: _____
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**
Revised 10/24/18