

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 Name: _____ 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 Name: _____ 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

Revised 8/27/2021

Date