Womens Health Center

# PATIENT INFORMATION & AUTHORIZATION

This form is confidential. We appreciate your cooperation in completing this form thoroughly.

We will be happy to bill your insurance for services; however, the patient or the patient's responsible party is ultimately responsible for payment of any medical services rendered.
**CO-PAYMENTS ARE ALWAYS DUE AT THE TIME SERVICES ARE RENDERED.**

**PLEASE PRINT:**

Patient's Name: _____ DOB: _____ Marital Status: S M P D W
Address: _____ SS#: _____
City: _____ State: ____ Zip: _____ Occupation: _____
Driver's License: _____ □ Home Phone: (_____)_____
Employer: _____ □ Cell Phone (_____)_____
Employer's Address: _____ □ Work Phone (_____)_____
City: _____ State: ____ Zip: _____ *Please check which phone you would prefer to receive calls.*
Referred by:_____ Okay to leave messages? Yes No
Patient's Email Address: _____

**Spouse or Responsible Party**

Name: _____ Relationship to Patient: _____
Address: _____ Date of Birth: _____
City: _____ State: ____ Zip:_____ SS#: _____
Employer: _____ Occupation: _____
Employer's Address: _____ Telephone (___)_____Which type: _____
City: _____ State: ____ Zip: _____ Work Phone (____)_____

**Medical Insurance Information**

Primary Ins. Co.: _____ Secondary Ins. Co.: _____
Subscriber: _____ Subscriber: _____
Policy #: _____ Policy #: _____

**Emergency Notification:** PLEASE GIVE THE NAME OF SOMEONE NOT LISTED ABOVE
Name: _____ Relationship: _____Telephone (___)_____
Address: _____ City: _____ State: _____ Zip: _____

**Authorization**
**I authorize the following person(s) to discuss any and all aspects of my medical condition and treatment with my physician. I understand that I can rescind this authorization at any time by submitting a written request.**

**Name of person(s) with whom protected health information may be discussed:**
_____ Relationship: _____
_____ Relationship: _____

**I authorize and consent to treatment of the above minor child:**
Signature of Parent or Guardian: _____ Relationship: _____

**I authorize the payment of medical/surgical benefits to physician. I acknowledge that I am responsible for payment of all charges.**
Signature: _____ Date: _____