



Information for Medical Records (Please Print)

Patient Name _____
LAST LEGAL FIRST MIDDLE INITIAL
 Name you prefer to be called _____ Maiden Name: _____
 Birthdate _____ Age _____ SOCIAL SECURITY # _____
 Home Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Work Phone () _____ Cellular Phone () _____
 Who referred you to this office? _____ Phone # _____ City / State _____
 Patient's Information, please check () one:
 Marital Status (✓): Single Married Divorced Separated Widowed
 Employment Status (✓): Part time Full time Not Employed Retired Self Active Duty Unknown
 Student (✓): N/A Full-time Part-time Pregnant: Yes No LMP Date _____
 Patient Employed by _____ Occupation _____
 Patient Work Address _____

Spouse's Name (or parent, if patient is a minor)

_____ Home Phone () _____
LAST FIRST MIDDLE INITIAL
 Home Address _____ City _____ State _____ Zip _____
 Social Security # _____ Birthdate _____
 Employer _____ Address _____ Phone # _____

Emergency Contact (Friend or Relative NOT living with patient)

Name _____ Phone () _____ Relation to patient _____

Medical Insurance Information

PRIMARY INSURANCE

Name of Insurance Company _____
 Address _____
 City / State _____ Zip Code _____
 Policy Holder _____
LAST FIRST MIDDLE INITIAL
 Policy Holder Date of Birth _____ Policy Holder Social Security # _____
 How is policy holder related to patient?
 Self Spouse Father Mother Other _____
 Policy in effect from _____ to _____ Group # _____
 Patient Policy # _____
 Subscriber Policy# (if different than patient's) _____
 Copayment per visit \$ _____ Deductible \$ _____
 Precertification needed? Yes / No Phone # _____

SECONDARY INSURANCE

Name of Insurance Company _____
 Address _____
 City / State _____ Zip Code _____
 Policy Holder _____
LAST FIRST MIDDLE INITIAL
 Policy Holder Date of Birth _____ Policy Holder Social Security # _____
 How is policy holder related to patient?
 Self Spouse Father Mother Other _____
 Policy in effect from _____ to _____ Group # _____
 Policy # _____
 Subscriber Policy# (if different than patient's) _____
 Copayment per visit \$ _____ Deductible \$ _____
 Precertification needed? Yes / No Phone # _____

Does insurance policy require a particular hospital for surgery?

Via Christi Wesley Other _____

Primary Care Physician

Name _____ Phone # _____
 Address _____

Please sign and return to receptionist

I hereby authorize my insurance benefits to be paid directly to Associates of Women's Health, P.A. for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance or workmen's compensation. I acknowledge and certify that my information is accurate. I hereby authorize Associates of Women's Health, P.A. to release all pertinent medical information necessary to insurance carriers. A photocopy of the authorization and assignment shall be considered as valid as the original.

Date _____ Signed _____