

Doctor:

Account #

# PLEASE PRINT

## PATIENT INFORMATION/YEARLY UPDATE

DATE: \_\_\_\_\_

PATIENT'S NAME		MARITAL STATUS S   M   W   D   SEP					DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	
STREET ADDRESS		PERMANENT	TEMPORARY	CITY AND STATE			ZIP CODE	HOME PHONE NO.		
PATIENT'S CELL NUMBER				PATIENTS EMAIL ADDRESS						
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF A STUDENT)			HOW LONG EMPLOYED		BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS					CITY AND STATE			ZIP CODE		
PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN SPOUSE)				ADDRESS				PHONE NO.		
SPOUSE OR PARENT'S NAME				DATE OF BIRTH			SPOUSE OR PARENT'S SS NO.			
SPOUSE OR PARENT'S EMPLOYER				OCCUPATION (INDICATE IF A STUDENT)			HOW LONG EMPLOYED		BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS				CITY AND STATE			ZIP CODE			

**PLEASE READ:** ALL CHARGES ARE DUE AT THE TIME OF SERVICE.

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		INSURED'S NAME			EFFECTIVE DATE
INSURED'S EMPLOYER		INSURED'S ID#		PATIENT'S RELATIONSHIP TO INSURED SELF      SPOUSE      CHILD	

SECONDARY INSURANCE COMPANY		INSURED'S NAME			EFFECTIVE DATE
INSURED'S EMPLOYER		INSURED'S ID#		PATIENT'S RELATIONSHIP TO INSURED SELF      SPOUSE      CHILD	

FAMILY DOCTOR	ADDRESS	PHONE	REFERRED BY
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**\* I have received a notice of the Privacy Practices from Women's Health Care, P.C.**

Date \_\_\_\_\_ Patient \_\_\_\_\_

Date \_\_\_\_\_ Spouse/Parent \_\_\_\_\_

**(OVER)**

**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
AND CLAIM PAYMENT AUTHORIZATION**

I HEREBY AUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT (PARENT OR GUARDIAN, IF MINOR)

I HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. I AGREE TO PAY ALL ATTORNEY FEES AND COURT COSTS INCURRED IN COLLECTING ANY UNPAID BALANCES FOR SERVICES RENDERED.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RESPONSIBLE PERSON, POLICY OWNER, INSURED

**STATEMENT TO PERMIT PAYMENT OF BENEFITS  
TO PROVIDER, PHYSICIAN AND PATIENT**

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE ABOVE NAMED PHYSICIAN(S).

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE