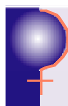

PARTNERS IN WOMEN'S HEALTH

Patient ID #:____________________ Date: ________ Doctor Name:__________________________

☐ I HAVE RECEIVED A COPY OF PARTNERS IN WOMEN'S HEALTH PRIVACY NOTICE____________(Please Date)

Name: ______________________________

Address:______________________________

____

City, State, Zip:______________________________

Phone: (___) __________ [ ]Home [ ] Work [ ]Mobile

Phone: (___) __________ [ ]Home [ ] Work [ ]Mobile

Phone: (___) __________ [ ]Home [ ] Work [ ]Mobile

Patient's Employer:

Employer Name: ________________________

Phone: ________________________

Employer Address: ________________________

Occupation: ________________________

Date of Birth: ____________ Age: ______

Social Security #: ________________________

Marital Status: ________________________

Referring Physician: ________________________

Primary Care Physician: ________________________

IF MARRIED, NAME OF SPOUSE

Spouse's Name: ____________________________

DOB: __________SSN: ____________________

IF PATIENT IS A CHILD, NAME OF MOTHER & FATHER:

____

CHILD LIVES WITH: MOTHER / FATHER

IN CASE OF EMERGENCY, CONTACT: (Someone in another household, i.e., grandparent, friend, etc.)

Name: __________________________ Relationship: ______________ Phone: ________________

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? IF YES, PLEASE LIST: _______________________

PRIMARY INSURANCE

NAME OF PERSON CARRYING INSURANCE: ____

GUARANTOR PHONE: ____________________ SS#: ____________________ DOB: _____________

YOUR RELATIONSHIP TO PERSON CARRYING INSURANCE: __________________ COPAY: _______________

PLACE OF EMPLOYMENT OF PERSON CARRYING INSURANCE: ____________________________________

NAME OF INSURANCE CO : __________________________ EFFECTIVE DATE: ___________________

INSURANCE I.D.#: ________________________________ GROUP #: ________________________

ADDRESS TO SEND CLAIM: ____

SECONDARY INSURANCE

NAME OF PERSON CARRYING INSURANCE: ____

GUARANTOR PHONE: ____________________ SS#: ____________________ DOB: _____________

YOUR RELATIONSHIP TO PERSON CARRYING INSURANCE: __________________ COPAY: _______________

PLACE OF EMPLOYMENT OF PERSON CARRYING INSURANCE: ____________________________________

NAME OF INSURANCE CO : __________________________ EFFECTIVE DATE: ___________________

INSURANCE I.D.#: ________________________________ GROUP # : ________________________

ADDRESS TO SEND CLAIM: ____

<u>AUTHORIZATION TO PAY INSURANCE BENEFITS & RELEASE INFORMATION TO INSURANCE COMPANY</u>

I hereby authorize payment directly to Partners in Women's Health. I understand I am financially responsible for charges not covered by this authorization. I authorize Partners in Women's Health to release information required to complete my insurance claim.

PATIENT OR GUARDIAN'S SIGNATURE:________________________________ DATE:____________