Patient Information

Date _____ /_____ /_______ Pharmacy Name ____ Phone ________ - _______ - __________

Patient's Name ____ Social Security # ________ - _______ - __________

DOB _____ /_____ /_______ Address _________________________________ City ___________________________ ST ______ Zip _________

Home Phone ________ - _______ - __________ Work Phone ________ - _______ - __________ Cell Phone ________ - _______ - __________

Email Address ____

Patient's Employer ____ Occupation ___________________________

Employer's Address ______________________________________ City __________________________________ ST ______ Zip _________

Spouse/Guardian's Name _________________________________ DOB _____ /_____ /_______ Social Security # ________ - _______ - __________

Spouse/Guardian's Employer __________________________________ Occupation ________________ Work Phone ______ - _____ - ________

RESPONSIBLE PARTY / GUARANTOR FOR SERVICES

Name ____ Relationship ________________________________

Address ____ Social Security # ________ - _______ - __________

Employer ____ Daytime Phone ________ - _______ - __________

Guarantor Signature ____

INSURANCE INFORMATION

Primary Insurance Company ____ Network _____________________

Insurance Company Address _______________________________________ City ___________________________ ST ______ Zip _________

Policy/ID# ____ Group# ____________________________________

Name of Policy Holder ___________________________________ DOB _____ /_____ /_______ Social Security # ________ - _______ - __________

Relationship ____

Secondary Insurance Company ____ Network _____________________

Insurance Company Address _______________________________________ City ___________________________ ST ______ Zip _________

Policy/ID# ____ Group# ____________________________________

Name of Policy Holder ___________________________________ DOB _____ /_____ /_______ Social Security # ________ - _______ - __________

Relationship ____

Emergency Contact ___________________________________ Phone ________ - _______ - __________ Relationship ________________________

PATIENT AUTHORIZATION

As a courtesy to our patients, Women's Medical Associates will file your insurance. I hereby authorize Women's Medical Associates to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits to include Medicare benefits directly to Women's Medical Associates. I further authorize the release of any pertinent medical records to any physician and/or facility to which I may be referred. I understand that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature ____ Date _____ /_____ /_______

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