

HEALTH CARE FOR WOMEN, P.A.

Patient Name: _____ DOB: _____ Age: _____

Social Security #: _____ Single Married Widowed Divorced (Please circle one)

Ethnicity: Hispanic/Latino Y or N Race: White American Indian Asian African American Pacific Islander Other Declined

Mailing Address: _____ City/State: _____ Zip: _____

Preferred Phone: _____ Emergency Contact Name/Phone: _____

Employer: _____ Work Phone: _____

Family Doctor: _____ Who referred you to us? _____

Reason for Visit: _____

RESPONSIBLE PARTY – Self / Spouse / Parent / Guardian (Please circle one)

Name: _____ DOB: _____ Male / Female

Social Security #: _____ Address: _____

City/State: _____ Zip: _____ Phone: _____

Employer: _____ Work Phone: _____

Financial Responsibility Acceptance: _____ (Signature required for minor patient)

Primary Insurance Information (Must provide copy to be scanned) Policy Holder: _____

Insurance Co: _____

DOB: _____ Identification Number: _____ Group number: _____

Secondary Insurance Information (Must provide copy to be scanned) Policy Holder: _____

Insurance Co: _____

DOB: _____ Identification Number: _____ Group number: _____

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT. IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID A THE CONCLUSION OF EACH VISIT. Thank you.

If this account is assigned to an attorney and/or collection agency, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to m y dependent or me. This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____