



Patient Information

Last Name _____ First Name _____ M.I. _____ Maiden or Nickname _____

Street Address _____ Apt. _____ PO Box _____ City _____

State _____ Zip _____ DOB _____ Last Four Digits of SS# _____ Preferred Language _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other **Ethnicity** ☐ Hispanic ☐ Non-Hispanic

Race ☐ Asian ☐ Black ☐ Caucasian ☐ Multi-Racial ☐ Native American ☐ Pacific Islands ☐ Other

Home phone: _____ Work phone: _____ Ext _____ Cell phone: _____

Primary # to call me: ☐ H ☐ W ☐ C

Email address _____ May we email you for other than medical reasons? ☐ Yes ☐ No

Employer _____ Employer Address _____

Occupation _____ If Student ☐ Full time ☐ Part time School Name _____

Insurance Information

Do you have health insurance? ☐ Yes ☐ No

Primary Insurance _____ Insurance Address _____

Policy # _____ Group # _____ Copay _____

Policy Holder _____ DOB _____ Relationship _____

Secondary Insurance _____ Insurance Address _____

Policy # _____ Group # _____ Copay _____

Policy Holder _____ DOB _____ Relationship _____

Complete for Policy Holder if other than self: Last Four Digits of SS# _____ Employer _____

Employer Phone # _____ Employer Address _____

Other Information

May we have your consent to obtain the list of all your current medications from pharmacy networks? ☐ Yes ☐ No

Primary Care Physician _____ Referring Physician _____

Primary Physician in This Office _____ Pharmacy Name & Phone _____

In case of Emergency/Urgent matter, we may contact: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

Name _____ Relationship _____ Phone # _____

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ Yes ☐ No

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand and acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

Signature of Patient or Parent of Minor _____

Date _____

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Patient's Signature _____

Date _____

Notice of Privacy: ☐ Received ☐ Refused _____

Signature of Patient or Parent of Minor _____

Date _____

May release protected health information to: _____

Name _____

Relationship _____