

**WOMEN'S HEALTH SPECIALISTS**

**PATIENT INFORMATION**

**Account #** \_\_\_\_\_

*PLEASE PRINT*

Patient Name \_\_\_\_\_  
Last First Initial

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Summer Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email address \_\_\_\_\_ Drivers license # \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Emergency Contact Name and Phone # \_\_\_\_\_

Who may we thank for referring you to our practice? : Name: \_\_\_\_\_

Referred by: \_\_\_\_\_ Doctor \_\_\_\_\_ Friend \_\_\_\_\_ Family Member \_\_\_\_\_ Insurance Company  
\_\_\_\_\_ Yellow Pages \_\_\_\_\_ Newspaper Ad \_\_\_\_\_ Radio Ad \_\_\_\_\_ TV ad

Who may we thank for this referral?: Name \_\_\_\_\_  
If patient is a minor: Parent name \_\_\_\_\_ Parent SS# \_\_\_\_\_

PRIMARY INSURANCE COMPANY: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Employer \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Employer \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health care practitioners participating in my care.
- I authorize and request my insurance company to pay directly to Women's Health Specialists insurance benefits otherwise payable to me. I understand that the insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize any holder of medical or other information to release to the Social Security Administration and the Centers for Medicare and Medicaid services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**X** \_\_\_\_\_  
Signature of patient (or parent if patient is a minor) Date