

The Women's Health Group



Demographic Information:

Patient Full Name: _____ Date of Birth: _____
Address: _____
Street Apt # City State Zip Code
Home Phone: _____ Email Address: _____
Cell Phone: _____ Name of PCP: _____

Check Race:

White Asian Black/African American
Hispanic/Latino American Indian/Alaskan Native
Native Hawaiian/Pacific Islander Other

Ethnicity: Hispanic/Latino Other Refused

Marital Status : Single Married Divorced
Domestic Partner Widowed

**** I am giving consent for pre-recorded appointment reminders, test results and/or financial obligations to be left by voice message or text at the following phone number: _____ ****

Emergency Contact Name: _____ Phone Number: _____
Relationship to Patient: _____

Insurance Information:

Primary Insurance: Phone Number: _____
Subscriber Name if not Patient: Subscriber DOB: _____
Member ID: Group Number: _____
Relationship To Subscriber: _____

Secondary Insurance: Please Provide Company, Subscriber, Member ID & Group # If You Have Another Insurance

You MUST let us know if you have additional insurance, especially Medicaid or Medicare. Failure to provide us with that information will result in you taking responsibility for any balance due from non-payment due to our inability to bill that insurance in a timely manner.

IF YOUR INSURANCE REQUIRES A REFERRAL FOR YOU TO SEE US, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE REFERRAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT – DUE TO NO REFERRAL – YOU THE PATIENT AGREE TO PAY THE WOMEN'S HEALTH GROUP IN FULL FOR ANY CHARGES INCURRED DURING YOUR VISIT.

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE **The Women's Health Group** TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO THE WOMEN'S HEALTH GROUP. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER OR FOR MY FAILURE TO PROVIDE COMPLETE INSURANCE INFORMATION.

PATIENT SIGNATURE: _____ DATE: _____

I HAVE REVIEWED THE INFORMATION PROVIDED ON THIS FORM AND ALL INFORMATION IS CORRECT; OTHERWISE, I HAVE PROVIDED UPDATED INFORMATION FOR ANY INCORRECT INFORMATION LISTED.

PATIENT SIGNATURE: _____ DATE: _____