

For Internal Use Only  
PT ID Number \_\_\_\_\_  
Last Verified \_\_\_\_\_

Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Maiden or Nickname \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_ P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed  Partner  Other

Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_ Cell Phone # \_\_\_\_\_

E-Mail Address \_\_\_\_\_ May we email you?  Yes  No

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

Patient's Employer Information

Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State Zip

Occupation: \_\_\_\_\_ If Student  Full time  Part time School \_\_\_\_\_

Insurance Information - Primary / Secondary / Other Do you have health insurance?  Yes  No

Primary Insurance \_\_\_\_\_ Copy of Card?  Yes  No

Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Copy of Card?  Yes  No

Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_

Spouse's Or Parent's Information (If Patient is covered by Spouse's / Parent's Insurance)

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Phone # (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_

Emergency Information: List nearest relative preferably not living with you.

In case of an emergency, we may contact: \_\_\_\_\_  
\_\_\_\_\_  
Telephone No. Relationship to Patient

Other

Primary Care Physician: \_\_\_\_\_ Primary Physician in This Office: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

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.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all 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 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