

WOMEN'S HEALTH AND SURGERY CENTER

YOUR HEALTH • YOUR BABY • YOUR LIFE

PATIENT INFORMATION (PLEASE PRINT)					
Last Name:		First Name:		Middle Name:	
Address:			City:	State:	Zip Code:
Home #:		Work #:		Cell #:	
Social Security # <u>(Required for Insurance)</u> :		DOB:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Employer:			Employer Address:		
Email Address:			How did you hear about us?		
Referring Physician:			Primary Care Physician:		
Pharmacy Name & Location:			Pharmacy Phone Number:		
INSURANCE INFORMATION					
Name of <u>Primary</u> Insurance:			Name of <u>Secondary</u> Insurance:		
Subscriber Name:			Subscriber Name:		
Subscribers Relationship to Patient:			Subscribers Relationship to Patient:		
Subscriber DOB:		Subscriber Social Security #:		Subscriber DOB:	
				Subscriber Social Security #:	
EMERGENCY CONTACT INFORMATION					
Last Name:		First Name:		Relationship To Patient:	
Address:			City:	State:	Zip Code:
Home #:		Cell #:		Work #:	
<p>Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice.</p> <p>Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33% and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice if required to collect my debt owed.</p>					
Signature of Responsible Party:				Date:	