Confidential

Institute For Women's Health

Dr.______________

Acct: SSN:	Phone: ( ) Cell: ( )
Last Name:	Date of Birth: / / Age:
First Name:	Patient Employer:
Address 1:	Occupation:
Address 2:	Phone #: ( )
City:	☐ Single ☐ Married ☐ Divorced ☐ Widowed
State: Zip: Country:	Drivers License / ID#:
Spouse:	Religion:
PCP: Last Name First Name	Email:
Phone #: ( )	

Primary Insurance:	**Secondary Insurance:**
ID #: Group:	ID #: Group:
Phone: ( ) Relation:	Phone: ( ) Relation:
Relationship: ☐ Self ☐ Spouse ☐ Child	Relationship: ☐ Self ☐ Spouse ☐ Child
Social Security #: DOB:	Social Security #: DOB:
Employer Name:	Employer Name:
Employer Telephone: ( )	Employer Telephone: ( )

IN CASE OF AN EMERGENCY CONTACT: (Two relatives not living with you, or friend in area).

Name:	Name:
Address:	Address:
Phone: ( ) Relation:	Phone: ( ) Relation:

PHARMACY INFORMATION:

Name:	Phone: ( )
Address:	E-Mail
Fax: ( )	

How did you hear about the Institute For Women's Health?

☐ Family ☐ Friend ☐ Co-worker ☐ Insurance ☐ Radio ☐ Internet ☐ Healthfair

☐ TV ☐ Phonebook ☐ Primary Care Physician ☐ Other

Doctor or person who Refferred you: ______________________________ May we thank this person? Yes ☐ No ☐

AGREEMENTS OF BENEFITS:

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS, TO INSTITUTE FOR WOMEN'S HEALTH. I UNDERSTAND THAT I AM RESPONSIBLE FOR SCHEDULING WITH A PARTICIPATING PHYSICIAN AND TO FOLLOW UP ON ANY DISCREPANCY IN COVERAGE WITH MY INSURANCE PLAN. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE INSTITUTE FOR WOMEN'S HEALTH TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signed: ____ Date: ___________________________