

## Women's & Family Care Patient Information Record

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # ( ) \_\_\_\_\_  
Street City State Zip

Mobile Telephone # ( ) \_\_\_\_\_ Preferred Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Telephone # ( ) \_\_\_\_\_

Marital Status: M S D W Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Spouse's SS# \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Work Telephone # ( ) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Student? Yes FT PT School \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

OB/GYN \_\_\_\_\_ Pediatrician \_\_\_\_\_

Other Physician Providers: \_\_\_\_\_

Dentist \_\_\_\_\_ Orthodontist \_\_\_\_\_

Interests/Hobbies \_\_\_\_\_

Who May We Thank For Referring You To Our Practice? \_\_\_\_\_

May we have your permission to call or write and thank them? Y N

Planned Method of Payment: ( ) Insurance/Medicaid/Medicare Name of Insurance Co: \_\_\_\_\_

Insurance Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Relation to Patient: \_\_\_\_\_  
( ) Self Pay ( ) Care Credit Application Completed ( ) Cash ( ) Credit Card ( ) Check

People with whom you may discuss my medical care: \_\_\_\_\_

Please call my ( ) Home #, ( ) Mobile #, ( ) Work# with questions/lab results.

Please do not call me with lab results but mail them. ( )

**Please Note:** This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

**Payment for office charges is expected at the time services are rendered.**

I currently have Advance Directives in place and will provide a copy as soon as possible. ( )

### Insurance Authorization and Assignment

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.** I also understand that if I am a Medicare Beneficiary and Medicare does not cover the services I receive, I will be responsible for the charges. I authorize payment by my insurance company directly to Comprehensive Women's Care, Inc. D/B/A Women's & Family Care.

I have received Comprehensive Women's Care, Inc. D/B/A Women's & Family Care, New Patient Packet, Advanced Directive Information, Patient Rights and Responsibilities, Financial Policies and Notice of Privacy and understand the policies and procedures as well as my rights in general and specifically related to my finances and personal health information. I authorize Comprehensive Women's Care, Inc. to release necessary personal health information to secure payment from third party payors.

SIGNED \_\_\_\_\_ Date \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

## Women's & Family Care Patient Information Record

### Medigap Lifetime Certificate

I request that payment of authorized Medicare/Medigap benefits be made to either me or on my behalf to Comprehensive Women's Care, Inc., D/B/A Women's & Family Care, any services furnished by these health care providers. I authorize any holder of my personal health information to release to the Health Financing Administration and its agents necessary personal health information necessary to determine these benefits of the benefits payable for related services. I understand that there are health care services that may not be paid for by Medicare. If Medicare does not cover these services, I understand that I will be responsible for paying for them.

Signature of Beneficiary \_\_\_\_\_ Medicare/Medigap # \_\_\_\_\_

Date Signed \_\_\_\_\_ Medigap Insurer \_\_\_\_\_