The Women's Health Group

Demographic Information:

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

Check or Circle Identity

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: _____
Subscriber ID: _____ Group Number: _____
Relationship To Patient: _____

***Secondary* Insurance: Please Provide 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: _____