Comprehensive Women's Health Care

Patient Information Record

Patient will be responsible for all charges if form is not enitrely complete

Patient Name _____ Nickname _____
Last First M.I.
Age _____ Gender ○ M ○ F Gender Identity: _____ Marital Status: S M W D Sep. DP
DOB _____ SS# _____ Gender Orientation _____ Race/Ethnicity: _____
Mailing Address _____
City State Zip
Email: _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Preferred Phone: ☐ Cell ☐ Home ☐ Work Preferred Method for Reminder Calls: VM Text Email
Employer _____ Occupation _____
Patient's Primary Care Doctor _____ Phone _____
How did you hear about our office? _____
Emergency Contact _____ Relationship _____ Phone _____
Spouse or Parent (if minor) _____ Phone _____

Primary Insurance Company _____
Name of Insurance
Claims Address _____
City State Zip
Phone _____ Effective date _____
ID/Policy # _____ Group # _____
Policyholder's Name _____ Relationship to Patient _____
Date of Birth _____ Policyholder's SS# _____ Phone _____
Policyholder's Employer _____

Other Insurance Company _____
Name of Insurance
Claims Address _____
City State Zip
Phone _____ Effective date _____
ID/Policy # _____ Group # _____
Policyholder's Name _____ Relationship to Patient _____
Date of Birth _____ Policyholder's SS# _____ Phone _____
Policyholder's Employer _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted, and understand the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary, I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____
Responsible Party Signature Date