Comprehensive Women's Healthcare

Patient Information Record

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

Patient Name _____ (Last) _____ (First) _____ (M.I.) Nickname _____

Age _____ Gender ○M ○F DOB _____ SS# _____ Marital Status: S M W D Sep. DP

Mailing Address _____ (City) _____ (State) _____ (Zip) email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Patient's Primary Doctor _____ Phone _____

How did you hear about our office _____

Emergency Contact _____ Relationship _____ Phone _____

Spouse or Parent (If minor) _____ Phone _____ Signed Consent Y N

Primary Insurance Company _____

Claims Address _____ (City) _____ (State) _____ (Zip) Phone _____

ID# _____ Group # _____

Effective Date _____ Copay _____

Policyholders's Name _____ Relationship to Patient _____ Date of Birth _____

Policy Holder's Social Security Number _____ Phone _____

Policyholder's Employer _____

Other Insurance Company _____

Claims Address _____ (City) _____ (State) _____ (Zip) Phone _____

ID# _____ Group # _____

Effective Date _____ Copay _____

Policyholder's Name _____ Relationship to Patient _____ Date of Birth _____

Policy Holder's Social Security Number _____ 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