

# TODAY'S WOMEN'S HEALTH SPECIALISTS

PLEASE PRINT

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_  
Name Address Phone Occupation

Emergency Contact \_\_\_\_\_  
Name Phone Relation

## REFERRAL SOURCE

Referred by:

\_\_\_\_ Physician/Provider Name \_\_\_\_\_

\_\_\_\_ Friend/Relative Name \_\_\_\_\_

\_\_\_\_ Other Please Specify \_\_\_\_\_

Examples: Health Plan/Insurance Company, Yellow Pages, Spanish Directory, Internet, Church Bulletin, Church Phone Book

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

ID # \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

## GUARANTOR/RESPONSIBLE PARTY (If different from patient)

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ DOB \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_  
Name Address Phone Occupation

## AUTHORIZATION, ASSIGNMENT & CONSENT TO TREAT

The patient or authorized person agrees that the above information is correct and allows for the medical treatment as specified by physician or associate provider.

I hereby authorize Today's Women's Health Specialists to release any information requested, including medical information, to any insurance company, employer, third party payer, or third party administrator for purposes of processing my claims. I hereby assign Today's Women's Health Specialists ALL payments for medical services rendered to myself or dependents. As the responsible party, I agree that I am responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, bad check charges, and court costs including any reasonable attorney fees.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_