

PATIENT INFORMATION

PRIMARY CARE DOCTOR: \_\_\_\_\_ PCP # \_\_\_\_\_ FAX # \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE # \_\_\_\_\_ CELLULAR # \_\_\_\_\_ RELIGION: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PATIENT EMAIL ADDRESS: \_\_\_\_\_

DRIVER'S LICENSE: \_\_\_\_\_ DRIVER'S LICENSE STATE: \_\_\_\_\_

EMPLOYER/SCHOOL: \_\_\_\_\_ TITLE: \_\_\_\_\_ PHONE # \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

TRANSLATOR NEEDED ( ) YES ( ) NO PRIMARY LANGUAGE SPOKEN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

PHONE # \_\_\_\_\_ PHONE # \_\_\_\_\_

PRIMARY INSURANCE INFORMATION:

SECONDARY INSURANCE INFORMATION:

INSURANCE CO. \_\_\_\_\_

INSURANCE CO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

PHONE # \_\_\_\_\_

PHONE # \_\_\_\_\_

I.D. # \_\_\_\_\_ GRP # \_\_\_\_\_

I.D. # \_\_\_\_\_ GRP # \_\_\_\_\_

INSURED'S NAME OR # \_\_\_\_\_

INSURED'S NAME OR # \_\_\_\_\_

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

IS THIS AN EMPLOYER'S PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # \_\_\_\_\_ DOB: \_\_\_\_\_

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RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

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GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the physician in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In these circumstances, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

SIGNATURE (Patient's parent if minor): \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION\***

I, \_\_\_\_\_ (Patient name), *authorize* Femlife Healthcare for Women, LLC to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)\*

- 1) \_\_\_\_\_ Relationship: \_\_\_\_\_
- 2) \_\_\_\_\_ Relationship: \_\_\_\_\_
- 3) \_\_\_\_\_ Relationship: \_\_\_\_\_

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- \* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
- \* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

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Please list any *additional* phone numbers where you would like us to contact you for:

- \* Results – Lab, X-ray, Ultrasounds, Mammograms, etc.
- \* Reminder notices
- \* Changes on scheduled appointments

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**ADVANCE DIRECTIVE**

Do you have an Advance Directive / Living Will? ( ) YES ( ) NO  
If **yes**, please provide us with a copy for our records.

If **no**, please let us know if you require information.

**I was referred to Femlife Healthcare for Women By:**

- Friend                       Relative                       Physician                       Insurance
- Reputation of LLC’s Physician(s)       Existing Patient               Other