PATIENT INFORMATION

NAME (Last, First Middle)			SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		CITY, STATE, ZIP		SECONDARY/BILLING ADDRESS (If applicable)	
HOME PHONE		CELL PHONE		CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS	SMOKER?(Y/N)	VETERAN? (Y/N)	PRIMARY CARE PROVIDER	EMAIL ADDRESS
EMERGENCY CONTACT NAME AND PHONE NUMBER				HOW DID YOU HEAR ABOUT OUR OFFICE?	
WITH WHOM MAY WE DISCUSS YOUR MEDICAL INFORMATION? (PLEASE WRITE OUT SPOUSE, PARENT, ONLY ME, OR OTHER NAME)					

PATIENT EMPLOYER		SPOUSE EMPLOYER	
ADDRESS		ADDRESS	
CITY, STATE, ZIP		CITY, STATE, ZIP	
WORK PHONE	OCCUPATION	WORK PHONE	OCCUPATION

INFORMATION OF PRIMARY SUBSCRIBER ON INSURANCE

NAME (Last, First Middle)		SSN#	BIRTH DATE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP		SECONDARY/BILLING ADDRESS (IF APPLICABLE)	
HOME PHONE	CELL PHONE	WORK PHONE	CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS	SMOKER?(Y/N)	VETERAN? (Y/N)	PRIMARY CARE PROVIDER	EMAIL ADDRESS
RELATIONSHIP TO PATIENT		EMPLOYER / OCCUPATION			

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		POLIICY #
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMOUNT
CITY, STATE, ZIP	PHONE #	DEDUCTIBLE
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		POLIICY #
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMOUNT
CITY, STATE, ZIP	PHONE #	DEDUCTIBLE
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I understand that MomDoc Women for Women participates in many insurance plans. If I am not sure if my insurance is one of those accepted, I should call my plan and inquire if MomDoc Women for Women are part of my network. I understand that it is my responsibility to get any needed referrals before my visit. I understand that it is my responsibility to know and understand my benefits and coverage. I understand that I may request a refund of any credits on my account once all claims have been processed and paid.

I understand that all professional services rendered are charged to me, and that I am responsible for all fees, regardless of insurance coverage. I understand that it is customary for payment to be made when services are rendered unless other arrangements have been made in advance with an office manager. I understand that all co-pays are expected before being seen. I understand that reasonable late fees or collections fees may be assessed in the event of late payment or non-payment of balance.

I request that payment of authorized Medicare/insurance company benefits be made either to me or on my behalf to MomDoc Women for Women for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignments of benefits apply. I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim or insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. ☐Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provide penalties for withholding this information.)

I have read, understand and have been offered a copy of the Notice of Privacy Practices for Protected Health Information.

DATE_____

PATIENT NAME_____

DOB_____

SIGNATURE_____