PATIENT INFORMATION SHEET

Patient Name _____

Address _____ City _____ State _____ Zip Code _____

Phone: Primary _____ Other _____ Work _____

DOB_____ Social Security # _____ Email _____

Race: _____ Primary Language: _____ Ethnicity: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

GUARANTOR OF INSURANCE _____ Date of Birth _____

GUARANTOR EMPLOYER _____

Social Security #_____ Relationship to Patient: _____

ALTERNATE CONTACTS (*MUST HAVE AT LEAST ONE***)**

Name _____ Name _____

Relationship _____ Relationship _____

Phone _____ Phone _____

PHYSICIAN CONTACT INFORMATION

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

PHARMACY INFORMATION

Name _____ City _____ State _____

Phone _____ Fax _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization of payment of insurance benefits to be made directly to The Women's Clinic, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I authorize The Women's Clinic to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account owed. I authorize The Women's Clinic and its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due. I further agree that a photocopy of this agreement shall be as valid as the original. My signature below indicates that I have read this disclosure and agree to the terms herein described.

Signature _____ Date _____