**Women's Health Care**
At Frost Street
**A Medical Corporation**

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## Patient Information:

Account # ______________________

Patient's Name: ______________________ Age: ________ Birth Date: ______________

Maiden Name: ______________________ Home Phone # (      ) ______________

Home Address: ______________________ Cell Ph. Or Pager # (      ) ______________

City: ____________ State: ______ Zip Code: ________ Work # (      ) ____________ Ext. ______

Mailing Address: ( If Different From Above): ______________________

Social Security #: ____________ Driver's License #: ____________ State: ______ Marital Status: S / M / D / W

If Minor, Name of Parent or Guardian: ______________________ Phone: (      ) ______________

Social Security # of Parent/Guardian: ______________ Drivers License #: ____________ State: ______

Primary Care Doctor: ______________________ Phone: (      ) ______________

Name of Physician you previously saw for this condition: ______________Phone: (      ) ____________

*WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT THIS OFFICE?* ______________________

**Emergency Contact Information: Contact:** ____________**Relationship:** ________**Phone: (      )** ______

## Patient's Employment Information (Or Responsible Party, If Minor):

Name of Employer: ______________________Occupation ______________

Address: ______________________ City: ____________ State: ______ Zip Code: __________

## Spousal Information:

Spouse Name: ______________________ DOB: ____________ Social Security #: ______________

Employer's Name: ________________ Occupation: ____________ Phone: (      ) ____________

Health Insurance Contracted Labs: LabCorp: ______ Quest: ______ Sharp: ______ Other: ________

** <u>Call your Health Insurance Company before appointment to verify contracted lab information.</u>**

Health Insurance: Yes / No If yes, is it an: HMO: _____ PPO: _____ OTHER: ________

** *<u>Bring Insurance Card on date of your appointment otherwise payment for services will be required.</u>* **

Would you like an Advance Directive Form? Yes / No

I agree that payment is to be made at the time the service is rendered unless prior arrangements are made. I authorize Women's Health Care to bill my insurance and to receive the payment for Medical benefits directly and to furnish information to the insurance carrier concerning my illness and treatments. Regulations pertaining to medical assignment of benefits apply. I understand that I am responsible for all amounts not covered by my insurance as well as services provided outside of the office (Pap Interpretations, Labs, Ultra Sounds etc.). I further agree that in the event of non-payment, I will bear the cost of collections and court costs and reasonable legal fees, should action be required. I also understand that failure to cancel my appointment(s) or reschedule 24 hours in advance will be subject to a $25 charge. I agree that a photocopy of the authorization shall be valid as an original.

Patient Signature: ______________________________ Date: ______________

Signature of Responsible Party for Payment: ______________________ Date: ______________

**Acknowledgement of Receipt of Privacy Notice: (Complete this section below at your appointment time in the office.)**
I have been presented with a copy of Women's Health Care at Frost Street A.M.C., Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and request the following restriction(s) concerning the use of my personal medical information: ______________

______________________________________________

______________________________________________

Patient Signature: ______________________________Date: ______________

If not signed by patient, please indicate relationship to patient (e.g., Spouse, Parent, Legal Guardian)

Relationship: ______________________ Witnessed by: ______________________