Women's Health Care
At Frost Street
A Medical Corporation

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: ( ) ____________ Fax: ( ) ____________

Who Referred You To This Office? ______________ Name of Person Who Referred You: ______________

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

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: Unilab: ________ Quest:________ Sharp: ________ Other: __________
** Call your Health Insurance Company before appointment to verify contracted lab information.**
Health Insurance: Yes / No If yes, is it an: HMO: ______ PPO: ______ OTHER: __________
** *Bring Insurance Card on date of your appointment otherwise payment for services will be required.* **

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 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:

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Patient Signature: ______________________Date: ______________
If not signed by patient, please indicate relationship to patient (e.g., Spouse, Parent, Legal Guardian)

Relationship: ______________________ Witnessed by: ______________________