WOMEN'S HEALTH CARE ASSOCIATES
2003 Medical Parkway Suite 300 | Annapolis, MD 21401
p 410.266.6035 **f** 410.266.9284

PATIENT INFORMATION

First Name:	Middle:	Last:		
Social Security#:	Date of Birth:	e-mail		
Address:	City:	State:	Zip:	
Home Phone:	Employer:	Work Phone:		
Cell Phone:	The best time to contact me is: ☐ AM ☐ PM on my ☐ Home ☐ Work ☐ Cell			

☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Emergency Contact:	Phone #:	Relation:	
Primary Physician:	State:	Phone #:	
Whom may we thank for referring you?			
Preferred Pharmacy:	City:	Phone #:	

INSURANCE INFORMATION

Primary Insurance:	Effective Date:		
Address:	Phone:		
Subscriber's Name:	SS#	Relationship:	
Subscribers DoB:	Policy #:	Group #:	Copay:
Secondary Insurance: *if applicable*	Effective Date:		
Address:	Phone:		
Subscriber's Name:	SS#	Relationship:	
Subscribers DoB:	Policy #:	Group #:	Copay:

RESPONSIBLE PARTY: (the person responsible for the payment of any amount not covered by insurance company)

Name:	Relationship to Patient:		
Address:	City:	State:	Zip:
DOB:	SS #:	Home Phone:	Cell Phone:
Sex:	Marital Status:	Employer:	Work Phone:

Patient agreement and authorization to release information
I, undersigned, acknowledge the I am financially responsible for all services rendered to me by Women's Health Care Associates, P.A. I acknowledge that I am personally responsible for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage. I authorize Women's Health Care Associates, P.A. to release to my insurance carrier(s) any medical information necessary to obtain reimbursement. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

WHCA

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AUTHORIZATION TO RELEASE PERSONAL MEDICAL INFORMATION

First Name:	Middle:	Last:
Social Security#:	Date of Birth:	Phone:

I authorize Women's Health Care Associates, P.A. to discuss my medical information and to release my records to the person(s) listed below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that my consent to release/obtain information will expire in one (1) year.
I understand that I may withdraw this consent in writing at any time.

Patient Name: (printed) _____ Parent/Legal Guardian _____

Signature of Patient/Parent or Legal Guardian _____ Date _____

Witness _____ Date _____

SUBMIT