WOMEN'S HEALTH CARE ASSOCIATES P.A.

PATIENT INFORMATION SHEET

DATE: ___/_____/_____

PATIENT INFORMATION

Name:____
(First) (MI) (Last)

Address:____

City:____State:________Zip:__________

Home Phone: ___________________________ Cell Phone :___________________________

Employer: _____________________________________ Work Phone:______________________

The best time to contact me is: ☐ A.M. ☐ P.M. on my ☐ Home ☐ Work ☐ Cell

Social Security Number:______________________ Date of Birth:____________

Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse or Parent's Name:_____________________________ Phone: ______________________

Emergency Contact:_________________________________ Phone: ______________________

Relationship to Patient: _________________________

Primary Physician:_______________________________ Phone:___________________________

Referring Physician: ________________________________ Phone:________________________

Whom may we thank for referring you? ____

Preferred Pharmacy:__________________________________ Phone:________________________

INSURANCE INFORMATION

Primary Insurance:_______________________________________ Effective Date: ______________

Address:____ Phone:________________

Subscriber's Name: ____ DOB:_________________

Subscriber's SS#: _____-_____-______ Relationship to Patient:_______________________________

Policy Number:____________________ Group Number :____________Co-pay:$______

SECONDARY INSURANCE

DO YOU HAVE SECONDARY INSURANCE? ☐ Yes ☐ No

Secondary Insurance:_________________________________ Effective Date: _______________

Address:____ Phone:___________________

Subscriber's Name: ______________________________________ DOB:___________________

Subscriber's SS#: _____-_____-______ Relationship to Patient:__________________________

Policy Number:_______________________ Group Number :______________Co-pay:$_______

RESPONSIBLE PARTY

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

Name:_______________________________ Relationship to Patient: ______________________

Address:____

(City) (State) (Zip)

Phone - H: ___________________W: ____________________ Cell: ___________________

DOB:___________ Soc. Sec. #:____________________ Sex: M F Marital Status:___________

Employer: ______________________________ Occupation:______________________________

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

____

Printed name of Patient/Parent or Legal Guardian

WOMEN'S HEALTH CARE ASSOCIATES, P.A.

Debra Hardy-Cartwright, M.D. F.A.C.O.G.
Linda R. Follette, C.R.N.P.

Authorization to release personal medical information

Patient's Name:____

Patient's DOB:_____/_____/_____ S.S.#:_____-_____-_____ 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:_____________________________

Phone:____

Name:____ Relationship:_____________________________

Phone:____

Name:____ Relationship:_____________________________

Phone:____

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:__________________________________ Parent/Legal Guardian:____________________________
(Name Printed)

Signed:______________________________________ Today's Date:_______________________

Witness:_____________________________________ Today's Date:_______________________