

# Health Central Women's Care, PA

Patient ID:

Doctor:

Allocation Set:

PATIENT INFORMATION					
Patient's name:			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Name:		Social Security no.:		Birth date:	Age: Sex:
				/ /	<input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Home phone no.:		Work phone no.:
			( )		( )
P.O. box:		City:		State:	ZIP Code:
Current Employer: Employed / Retired / Unemployed / Other: _____					Employer phone no.:
					( )
Who referred you to our office?			Primary Care Physician:		

INSURANCE INFORMATION					
Policy Holder Name:		Birth date:	Social Security Number:		Relationship to Patient:
		/ /			
Employer:			Employer phone no.:		
			( )		
Primary Insurance Company:		Phone Number to Verify Benefits:		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS	
		( )			
Group Number:		ID/Policy Number:	Effective Date:		Co-Payment:
			/ /		\$
Secondary Insurance Company:		Phone Number to Verify Benefits:		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS	
		( )			
Group Number:		ID/Policy Number:	Effective Date:		Co-Payment:
			/ /		\$

IN CASE OF EMERGENCY		
Name:		Relationship to patient:
		Phone number:
		( )
<p>I authorize Health Central Women's Care, PA to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary to secure payment. I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other health plan to Health Central Womens Care, PA. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.</p>		
Patient/Guardian signature		Date