Health Central Women's Care. P.A.

Patient ID#
Doctor:
Date:
Allocation Set:

Patient Information

Name | Date of Birth: | Sex ( )M ( )F | Social Security #:

Email Address: | Marital Status: ( )Married ( )Single ( )Divorced ( )Widowed ( )Other | Driver's License#

Who referred you to our office: _____ Patient _____ Physician | Name: | Primary Care Physician:

Current Billing Address

Street | City, State, Zip

Home Phone: | Cell Phone:

Current Employer

( )Employed ( )Retired ( )Unemployed ( )Other

Employer: | Work Phone #/Ext:

Spouse or Responsible Party Information

Name: | Date of Birth: | Social Security #:

Address: | City, State, Zip

Employer: | Phone/Ext:

Emergency Contact

Name: | Relationship to the patient: | Phone:

Primary Insurance Information

Policy Holder Name: | Policy Holder Birthdate: | Policy Holder SSN: | Relationship to Patient:

Group # | Effective Date: | ID/Policy Number: | Copay:

Insurance Company Name | Phone # to Verify Benefits: | Phone # for Customer Service:

Insurance Claims Address | City, State, Zip | ( )HMO ( )PPO ( )EPO ( )POS

Secondary Insurance information

Policy Holder Name: | Policy Holder Birthdate: | Policy Holder SSN: | Relationship to Patient:

Group # | Effective Date: | ID/Policy Number: | Copay:

Insurance Company Name | Phone # to Verify Benefits: | Phone # for Customer Service:

Insurance Claims Address | City, State, Zip | ( )HMO ( )PPO ( )EPO ( )POS

Assignment of Benefits

I authorize Health Central Women's Care, P.A. to perform procedures and treatments including the administration of medicine and local anesthetics along with 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 Women's Care, P.A. 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.

Patient/Legal Guardian Signature: _____ Date: _____