Patient Information Sheet

Please Print and Fill In All Spaces

DATE ____________________

PHYSICIAN YOU ARE SEEING ______________ REFERRED BY ______________________ NAME YOU PREFER TO BE CALLED ______________________

LAST NAME ______________________ **FIRST** ______________________ MIDDLE ______________

BIRTHDATE ____________ AGE __________ RACE ______________ MAIDEN NAME ______________ RELIGION ______________

RESIDENCE/MAILING ADDRESS ____
STREET/ROUTE/OR P.O. BOX CITY STATE ZIP

PHONE ______________ YOUR WORK PHONE ______________ **SOCIAL SECURITY #** ______________ MARITAL STATUS ______
M S D W

EMPLOYED BY ______________________ OCCUPATION ______________________

HUSBAND/PARENT NAME ______________________ WORK PHONE ______________ SOCIAL SECURITY # ______________

HUSBAND/PARENT EMPLOYED BY ______________________ HUSBAND/PARENT OCCUPATION ______________________

NEAREST RELATIVE NOT LIVING WITH YOU ______________________ RELATIONSHIP ______________

ADDRESS ____ TELEPHONE # ______________
STREET/ROUTE/OR P.O. BOX CITY STATE ZIP

NAME OF INSURANCE ______________________ EMAIL ADDRESS ______________________

WOMENS HEALTH OF AUGUSTA, PC WANTS TO HELP YOU RECEIVE YOUR MAXIMUM INSURANCE BENEFITS. IN ORDER TO DO THIS, **YOU** NEED TO KNOW IF YOUR POLICY HAS ANNUAL PREVENTATIVE/ROUTINE COVERAGE. YOUR PHYSICIAN WILL DO HIS/HER BEST TO CODE YOUR VISIT ACCORDINGLY. HOWEVER, ONCE YOUR VISIT IS CODED AND DOCUMENTED, IT **CANNOT** BE CHANGED.

______________________________________ ______________________
SIGNATURE DATE

ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLE AMOUNTS MUST BE PAID AT THE TIME OF YOUR VISIT.

IF YOU DO NOT HAVE INSURANCE OR WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN PAYMENT IS EXPECTED IN FULL AT TIME OF SERVICE.

I UNDERSTAND AND WILL ABIDE BY THE PAYMENT POLICY ABOVE AND WILL ALSO BE RESPONSIBLE FOR ANY ADDITIONAL CHARGES SUBMITTED TO A RADIOLOGY OR LABORATORY FACILITY.

PATIENT'S SIGNATURE: ______________________________ DATE: ______________

INSURANCE PAYMENT ORDER

I hereby authorize and direct you to pay directly to Womens Health of Augusta, PC benefits due me out of indemnity under the terms of my policy issued by your company. Payment is authorized upon your receipt of an itemized statement for services rendered me. This policy was in full force and effect at the time that these services were rendered. Payment of this amount is hereby directed, in whole or in part, shall be considered the same as if paid by your company directly to me.

LEGAL SIGNATURE: ______________________________ DATE: ______________

MEDICAL RECORDS AUTHORIZATION RELEASE

I hereby authorize Womens Health of Augusta, PC to disclose, when requested to do so by insurance carrier(s) or its representatives for application to obtain insurance or to pay a claim, any and all information with respect to any illness, injury, medical history, consultation, prescription or treatment, including copies of all medical records.

LEGAL SIGNATURE: ______________________________ DATE: ______________