BLUEFIELD WOMEN'S CENTER, P.C.

PATIENT INFORMATION

PATIENT NAME:_____ S____ M____ W____ D____

ADDRESS:_____ CITY_____STATE_____ ZIP_____

D.O.B:_____ AGE:_____ RACE:_____ SOC. SEC.#:_____ CELL/HOME PHONE #:_____

2ND PHONE #_____ E-MAIL:_____

EMPLOYER & ADDRESS:_____

SPOUSE/PARENT INFORMATION

NAME:_____ D.O.B.:_____ SOC. SEC. #_____

EMPLOYER & ADDRESS:_____

INSURANCE

PRIMARY INS. NAME:_____POLICY#/ID#:_____ GROUP#:_____

SUBSCRIBER NAME:_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INS. NAME:_____ POLICY#/ID #:_____ GROUP #_____

SUBSCRIBER NAME:_____ RELATIONSHIP TO PATIENT:_____

IN CASE OF EMERGENCY

NAME:_____ RELATIONSHIP:_____ NUMBER:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION ACQUIRED DURING THE COURSE OF MY EXAMINATION AND TREATMENT THAT IS NECESSARY TO PROCESS MY MEIDCAL CLAIMS.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS TO THE FACILITY AND/OR PHYSICIAN: I HEREBY AUTHORIZE PAYMENT TO BLUEFIELD WOMEN'S CENTER, P.C. AND/OR DR. RANDY BRODNIK FOR MEDICAL AND/OR SURGICAL BENEFITS THAT MAY BE PAYABLE TO OR FOR ME, FOR SERVICES RENDERED IN THIS FACILITY.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO FACILITATE THE COLLECTION OF SUCH CHARGES THAT MAY BE INCURRED DURING MY EXPERIENCE AT BLUEFIELD WOMES'S CENTER, P.C. OR FOR SERVICES RENDERED TO ME (OR THE ABOVE MENTIONED MINOR) BY DR. BRODNIK AT THE HOSPITAL, TO THE BEST OF MY ABILITY.

BLUEFIELD WOMEN'S CENTER, P.C., AS A COURTESY, WILL SUBMIT CHARGES TO MY INSURANCE CARRIER, FOR SERVICES RENDERED. HOWEVER, IF FOR ANY REASON, MY INSURANCE COMPANY DOES NOT PAY FOR THE SERVICES WITHING A RESONABLE PERIOD OF TIME, I WILL BE FULLY RESPONSIBLE FOR ANY AND ALL BALANCES DUE ON MY ACCOUNT.

SIGNATURE:_____ **DATE:**_____