Patient Information Sheet

Name:_____
Mail Address_____
City, St., Zip: _____
Email:_____
Home #:_____
Cell #:_____
Work #:_____
DOB:_____ **Age**_____

How did you hear about our office?

_____
(Newspaper, TV, Office Sign, Patient, Referral etc.)

S.S. #_____ **Sex:** Female
Race: _____ **Ethnicity:**_____
Marital Status:_____
Maiden Name:_____
Referring Physician:_____
Family Physician:_____
Primary Physician:_____
Preferred Pharmacy_____
Pharmacy Address_____
City_____ **State** _____

PATIENT EMPLOYMENT
Employer/Student:_____
_____
Status: [ ]Full Time[ ]Part Time [ ]Retired[ ]Unemployed
Phone:_____
Employer Address:_____
_____

EMERGENCY CONTACT (other than patient)
Name *Phone#*
1)_____
2)_____
3)_____

GUARANTOR
[ ] Same As Patient
Name:_____
Mail Address _____
City, St., Zip_____
Phone #:_____
Relation to Patient:_____

GUARANTOR EMPLOYMENT
Employer: _____
Employer Address:_____
Employer Phone:_____
DOB:_____
S.S.#_____

Primary Ins:_____
Effective Date: _____
Address_____
City State Zip_____
Policy ID #:_____
Group #_____
Policy Holder:_____

Realtionship to Patient _____
Policy Holder DOB:_____
Policy Holder SSN:_____
Policy Holder Employer:_____
Policy Holder_____
Address_____
_____
Copay:_____

Secondary Ins:_____
Effective Date: _____
Address _____
City State Zip _____
Policy ID #:_____
Group #_____
Policy Holder:_____

Realtionship to Patient_____
Policy Holder DOB:_____
Policy Holder SSN:_____
Policy Holder Employer:_____
Copay:_____

IF MEDICARE SECONDARY:[ ]Working aged Beneficiary [ ]Disability[ ]Other

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PATIENT AUTHORIZATION

Authorization for Treatment: I authorize Alliance for Women's Health, Inc. to provde routine examinations, diagnostic test, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain until withdrawn in writing.

I hereby authorize release of my medical records and/or any pertinent information for medical care or insurance claim processing. I also am requesting payment for services rendered be made directly to Alliance for Women's Health, Inc.

I understand that any charges that are accrued to my account are my responsibility and regardless if my medical insurance pays or not any balance is my responsibility. Payment is due at the time services are rendered unless prior arrangements have been made. By signing, I understand and will adhere to the above

Patient Signature_____ Date _____

MINORS: (IF UNDER 18YRS. OLD)

As a minor, any information obtained in our office is confidential. With your signature, you are assuming responsibility for your treatment, care, and payments. We do encourage parental/guardian involvement. If you are using insurance through your parent/guardian, we must have their consent.

I decline having parental/guardian involvement for my care/treatment.

SIGNED: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____

**Use of Electronic Mail Agreement

The use of electronic mail to communicate with your doctor or this office is not meant for serious/urgent problems or emergencies. Please call our office if you are not sure of the nature of your problem and we will be glad to assist you. The billing office staff may utilize email to communicate with you in regards to insurance questions or billing requests. Due to HIPAA regulations we will refrain from sending personal health information via electronic mail (email)

By signing below, I acknowledge and allow the use of email for the billing office or appointment reminders and other communications, etc.

Patient Signature _____ **Date** _____