WOMEN'S EXECUTIVE HEALTHCARE, P.C.
Drina A. Northam, M.D.
A Division of Mid-Atlantic Women's Care, PLC
11747 Jefferson Avenue, Suite 1B Newport News, Virginia 23606
Telephone: (757) 592-9600 Facsimile: (757) 592-9727

PATIENT INFORMATION

Date: _____ _ Date of Birth: _____

Patient's Name: _____
First Middle Last

Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Social Security Number: _____ Marital Status (Circle) Single / Married / Divorce / Widow
Patient Email Address: _____

EMPLOYER INFORMATION

Email Address: _____
Employer: _____
Employer Address: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Plan: _____ Insurance Phone: _____
Insurance Company Address: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber Social Security Number: _____ Relationship to Patient: _____
Policy Number: _____ Group Number: _____

Secondary Insurance Plan: _____ Insurance Phone: _____
Insurance Company Address: _____
Subscriber Name: _____ Date of Birth: _____
Subscriber Social Security Number: _____ Relationship to Patient: _____
Policy Number: _____ Group Number: _____
Preferred Pharmacy: _____ Pharmacy Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____ Relationship to Patient: _____

Please read and sign below. Read these terms carefully.

- **I hereby affirm the information above is accurate and do authorize treatment of the above-named patient today and on all subsequent visits.**
- **I the undersigned patient or guarantor agree to be responsible for payment of treatment charges, and I understand that insurance coverage does not relieve me of this responsibility.**
- **I will be responsible for all reasonable costs of collection, attorney fees and court costs incurred in the collection of any amount due Women's Executive Healthcare PC.**
- **I understand that if I fail to cancel my appointment more than 24 hours in advance, I will be charged a cancellation fee of $30.00.**
- **I authorize the release of any information necessary to determine payment or collect reimbursement on any claim.**
- **I request that payment of benefits on my behalf and assign those benefits including Medicare, Private Insurance an other health plans to Women's Executive Healthcare PC.**

Signed: _____ Date: _____