Woman to Woman Gynecology, PLLC
Amy M Bruton, MD
Patient Information Sheet

Name
_____
__
First Middle Last
preferred

Home Phone_____ Cell Ph. _____Work Ph._____
Please include area code with phone numbers.

Email address_____
___

Address_____City_____State_____Zip_____
_____

Month/Day/Year of birth ____/____/_____ Social Security # _____-_____-_____

Marital Status: Single/ Married/ Divorced Spouse/Partner name:_____

Profession_____
Employer_____

Parent or Guardian (for minors)_____Phone #_____

Emergency Contact_____ Phone #_____

Contacts relationship to patient_____

Primary Care Physician_____ Referring Physician_____

How did you learn about us?
_____
_____
_____

Pharmacy Preference

Name of Pharmacy_____ Phone #
_____

Address of Pharmacy
_____

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Insurance

Primary Insurance

Name of insurance company _____
Employer_____

Name of insured _____Insured's SS#
_____

Insured's Month/Day/Year of birth ____/____/_____

Relationship to patient Self/ Spouse/ Parent

Secondary Insurance

Name of insurance company _____
Employer_____

Name of insured _____Insured's SS#
_____
(Usually the first name on the insurance card)

Insured's Month/Day/Year of birth ____/____/_____

Relationship to patient Self/ Spouse/ Parent

Patient Consent

Woman to Woman Gynecology, PLLC (hence forth W2W) will only use your health care information for the following reasons:

Treatment: W2W will use your health care information to make decisions about the provision, coordination or management of your healthcare, including but not limited to, analyzing or diagnosing your condition and determine the appropriate treatment for that condition. It may also be necessary to share your heath with another health care provider whom we need to consult with in respect to your care. By signing this you are acknowledging that you understand that treatment for any and or all of your conditions will be based upon the information which you provide. You are accepting of full responsibility should you provide inaccurate, incomplete or

misleading information. You are hereby certifying that the identifying information, address, and telephone information provided are correct and agree to inform W2W and its staff if and when such information changes or becomes outdated. You agree that W2W and staff cannot contact you if you have provided incorrect or illegible information or fail to keep your information up to date and correct. You agree to hold harmless W2W for any lack of communication due to any of the above.

Payment: W2W may need to use or disclose information in our health care record to obtain reimbursement from you, your health insurance carrier or from another entity for the services rendered to you. This may include, but not limited to, determinations of eligibility of coverage under the appropriate health plan, precertification, preauthorization of services and/or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system.

Operations: Your health care records may be used in our business planning and development operations, including but not limited too, improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities and arranging for legal and auditing functions.

I do hereby agree to allow and health care information to be used for the purpose of treatment, payment and operations as outlined above.

_____

_____/_____/_____

Patient signature Date