

TOTAL WOMEN'S CARE INC.

PERSONAL INFORMATION:

Patient Name _____ Date _____
Address _____ Age _____
City _____ State _____ Zip _____
Home Phone _____ Employer _____
Birth date _____ SS # _____ Work Phone _____
Cell Phone _____ Marital status-- Single Married Other (please circle)
Phone number you would prefer we call first _____
Mother's Maiden Name _____ Your Maiden Name _____

SPOUSE or GUARDIAN INFORMATION:

Name _____
Birthday _____ SS # _____
Employer _____ Phone _____
Emergency Contact _____ Relationship _____ Phone _____
(This person will be phoned in the event we need to contact you in an emergency and are unable to reach you or your next of kin.)

INSURANCE INFORMATION:

Name of Primary Insurance Co. _____
Address _____
I.D.# _____ Group# _____
Effective Date _____
Subscriber's Name & Birthdate _____ Relationship to Patient _____
Subscriber's Employer _____
Name of Secondary Insurance Co _____
Address _____
I.D.# _____ Group# _____
Effective Date _____
Subscriber's Name & Birthdate _____ Relationship to Patient _____
Subscriber's Employer _____

INSURANCE AUTHORIZATION, ASSIGNMENT AND GENERAL CONSENT

(Please Read and Sign)

I hereby authorize the physician to furnish information to insurance carriers concerning this treatment/ illness /accident and I hereby irrevocably assign to the doctor all payments for medical services rendered.

I understand that I am financially responsible for all charges whether or not covered by insurance.

I further understand that I am personally responsible for any unpaid balance.

I understand that information pertaining to alcohol and / or drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) may be contained in my medical record and may be furnished as part of my medical record pursuant to this Authorization, Assignment and General Consent.

Patient's Signature Date: _____

If Patient is a minor then Parent or Guardian Signature Date: _____