Gallatin Women's Center

William R. Caldwell, M.D.
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Date:____________________________

Patient Information:

Name: ____
(Last) (First) (Middle) (Maiden)

Address: ____
(Street) (City) (State) (Zip)

SSN: __________________ Home Phone: ____________________ Cell:__________________

Marital Status: __________ Date of Birth: _____________ Email Address: ______________________

Employer: _____________________ Work Phone: _________________ Religion: _______________

Primary Care Provider: _________________________________ Phone: _____________________

Preferred Pharmacy & Location: ____

Spouse Information:

Spouse Name: ___________________________________ Phone Number:___________________

Spouse Employer:_______________________________ Spouse Date of Birth:__________________

Emergency Contact:________________________________ Phone Number:___________________

Primary Insurance Information:

Subscribers Name:____ Date of Birth:____________

Relationship:____

Name of Insurance Company:____

Secondary Insurance Information:

Subscribers Name:____ Date of Birth:____________

Relationship:____

Name of Insurance Company:____

Assignment and Release:

I authorize Gallatin Women's Center to release any medical records necessary to process insurance claims, requests from attorneys, or referring physicians. I authorize payment of insurance benefits to be paid directly to Gallatin Women's Center. I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage or third party involvement. I understand that any costs associated with collection activity are the responsibility of the patient. In the event that my account is place with an outside agency for collection, I agree to pay all collection costs, court costs and attorney fees incurred to collect my account.

Signature:____