Women's Healthcare Associates

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PATIENT INFORMATION

PATIENT NAME_____ CELL PHONE (___)_____
LAST FIRST MI AREA CODE NUMBER

ADDRESS_____ HOME NUMBER (___)_____
NUMBER STREET UNIT/APT AREA CODE NUMBER

CITY_____ STATE_____ ZIP_____ EMAIL:_____

BIRTHDATE____/____/____ AGE_____ SS#_____ DL#:_____

RACE:_____ ETHNICITY:_____ LANGUAGE:_____

PHARMACY NAME AND PHONE NUMBER:_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ PHONE (___)_____
NUMBER STREET CITY STATE ZIP

(OPTIONAL)___MARRIED ___SINGLE ___DIVORCED ___WIDOWED ___SEPARATED RELIGION_____

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SPOUSE OR RESPONSIBLE PARTY NAME_____ PHONE (___)_____
AREA CODE NUMBER

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ PHONE (___)_____
NUMBER STREET CITY STATE ZIP AREA CODE NUMBER

RELATIONSHIP_____ SS#_____ BIRTHDATE ____/____/____

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REFERRED BY { }WEBSITE { }INSURANCE { }GOOGLE { }PATIENT { }DOCTOR_____
EMERGENCY CONTACT: NAME_____ RELATIONSHIP_____
ADDRESS_____ HOME NUMBER (___)_____
NUMBER STREET UNIT/APT AREA CODE NUMBER

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INSURANCE INFORMATION:
SUBSCRIBER NAME_____ PRIMARY CARRIER_____
CERTIFICATE #_____ GROUP#_____ EFFECTIVE DATE_____

SUBSCRIBER NAME_____ SECONDARY CARRIER_____
CERTIFICATE #_____ GROUP #_____ EFFECTIVE DATE_____

AUTHORIZATION AND ASSIGNMENT:
I HEREBY AUTHORIZE THE SANTA MONICA WOMEN'S HEALTHCARE ASSOCIATES TO FURNISH MY INSURANCE COMPANY ALL INFORMATION WHICH THEY MAY REQUEST CONCERNING MY ILLNESS AND TREATMENT. I HEREBY ASSIGN TO THE SANTA MONICA WOMEN'S HEALTH ASSOCIATES ALL INSURANCE PAYMENTS TO WHICH I AM ENTITLED FOR MEDICAL AND/OR SURGICAL SERVICES RENDERED TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE AND/OR BENEFITS. A COPY OF THIS ASSIGNMENT IS AS VALID AS THE ORIGINAL.

PATIENT'S SIGNATURE_____ DATE_____