PATIENT INFORMATION

PRIMARY CARE DOCTOR: _____ PCP # _____ FAX # _____

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____

SOCIAL SECURITY # _____ MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE # _____ CELLULAR # _____ RELIGION: _____

STREET ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT EMAIL ADDRESS: _____

DRIVER'S LICENSE: _____ DRIVER'S LICENSE STATE: _____

EMPLOYER/SCHOOL: _____ TITLE: _____ PHONE # _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE NAME: _____ BIRTHDATE: _____

TRANSLATOR NEEDED ( ) YES ( ) NO PRIMARY LANGUAGE SPOKEN: _____ REFERRED BY: _____

****

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME: _____ PHONE # _____ RELATIONSHIP: _____

ADDRESS: _____ CITY : _____ STATE: _____ ZIP: _____

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IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: _____ FATHER'S NAME: _____

EMPLOYED BY: _____ EMPLOYED BY: _____

PHONE # _____ PHONE # _____

****

PRIMARY INSURANCE INFORMATION:

INSURANCE CO. _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE # _____

I.D. # _____ GRP # _____

INSURED'S NAME OR # _____

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # _____ DOB: _____

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

SECONDARY INSURANCE INRORMATION:

INSURANCE CO. _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE # _____

I.D. # _____ GRP # _____

INSURED'S NAME OR # _____

IS THIS AN EMPLOYER'S PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # _____ DOB: _____

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the physician in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered. unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event if becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In these circumstances, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

SIGNATURE (Patient's parent if minor): _____ DATE: _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, _____(Patient name), *authorize* Femlife Healthcare for Women, LLC to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

****

* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

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Please list any *additional* phone numbers where you would like us to contact you for:

* Results – Lab, X-ray, Ultrasounds, Mammograms, etc.
* Reminder notices
* Changes on scheduled appointments

1. _____

2. _____

Patient Signature: _____

ADVANCE DIRECTIVE

Do you have an Advance Directive / Living Will? ( ) YES ( ) NO
If **yes**, please provide us with a copy for our records.

If **no**, please let us know if you require information.

I was referred to Femlife Healthcare for Women By:

☐ Friend ☐ Relative ☐ Physician ☐ Insurance
☐ Reputation of LLC's Physician(s) ☐ Existing Patient ☐ Other