



tending to the unique nature of women

Date: _____

Patient Information Form

Full Name:			
Street Address:	City:	State:	Zip:
Employer/School:	Occupation:		
Employer Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Email Address:			
Date of Birth:		SS#:	
Patient ID/Nickname:	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Driver's License #:	
Insured's Full Name:	Insured's Employer:		
Employer's Address:	City:	State:	Zip:
Work Phone #:	Insured's SS#:	Date of Birth:	
Spouse's Full Name:	Spouse's Employer:		
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list medications:		
Nearest relative not living with you:		Phone #:	
Do you have medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred by:		
Primary Care Physician:			

Primary Insurance to File

Policy Number:	Group Number:
Insured's Name:	Relationship to Patient:
Insured's SS# or ID Number:	
Insurance Company Name:	Insurance Company Phone Number:
Insurance Company Address:	City: State: Zip:

Secondary Insurance to File

Policy Number:	Group Number:
Insured's Name:	Relationship to Patient:
Insured's SS# or ID Number:	
Insurance Company Name:	Insurance Company Phone Number:
Insurance Company Address:	City: State: Zip:

I understand that payment is due at the time of service is rendered. I hereby authorize the release of any medication to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows Columbia Women's Healthcare, L.L.C. to release any information to any of my insurers or physicians as requested by any such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND ANY OTHER HEALTH PLANS TO COLUMBIA WOMEN'S HEALTHCARE, L.L.C.. COLUMBIA WOMEN'S HEALTHCARE, L.L.C. DOES NOT EXTEND CREDIT. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO AN ATTORNEY AT LAW FOR COLLECTIONS.

Responsible Party's Signature (if different):	Date:
Patient's Signature:	Date:

None of the above information has changed since my last visit.

Patient's Signature: _____ Date: _____