



The Center For Women's Health

Please Print Clearly

Chart# _____

Name _____ Social Security # _____
Street Address _____ Apt/Lot # _____
City _____ State _____ Zip _____ Drivers License # _____
Home Phone (____) _____ Cell Phone (____) _____
Email Address _____ Date of Birth _____
Sex: F / M Race _____ Marital Status: single/ married/ divorced Student: full/ part time
Employed: full/ part/ retired/ not Employers Name _____
Employer's Address _____ Phone _____

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Name of Primary Care Physician _____ Phone # _____
Name of Physician who referred you _____ Phone # _____
How did you hear about us _____
(friend, seminar, website, yellow pages, billboard, other)

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Spouse or Parent's Information if patient is a minor: (please circle " spouse or parent")
Name _____ SS # _____
Street Address _____ Apt/Lot _____
City _____ State _____ Zip _____ Drivers License _____
Home Phone (____) _____ Cell Phone (____) _____
Date of Birth _____ Sex F/ M Race _____ Marital Status single/married / divorced
Employed full/ part/ retired/ not Employers Name _____
Employers Address _____ Phone(____) _____

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Primary Insurance _____ Policy # _____ Group# _____
Insured's Name _____ Date of Birth _____
Secondary Insurance _____ Policy# _____ Group# _____
Insured's Name _____ Date of Birth _____

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In case of emergency, whom should we contact? _____
Relationship: _____ Home Phone:(____) _____ Cell:(____) _____

**Authorization for Medical and/or Surgical Treatment
and release of Medical Information for Claims Processing/ Financial Responsibility**

I hereby authorize The Center For Women's Health staff, and whomever they delegate, to provide medical, emergency and in-patient care and treatment as necessary. I also authorize the release of any medical information necessary to process insurance claims and authorize payments from insurance companies to be made to The Center For Women's Health.

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney 's fees and costs for collection in the event of default. I further understand that if payment becomes 120 days past due, delinquency at the lesser of the annual rate of 35%, or the maximum allowable rate, will be due in delinquent amounts from the date payment was due.

Patient signature: _____ Date _____

Parent/Guardian Signature (if patient is minor) _____ Date: _____

Witnessed by: _____ Date: _____