



PARTNERS IN WOMEN'S HEALTH

Patient ID #: _____ Date: _____ Doctor Name: _____

☐ I HAVE RECEIVED A COPY OF PARTNERS IN WOMEN'S HEALTH PRIVACY NOTICE _____ (Please Date)

Name: _____	Date of Birth: _____ Age: _____
Address: _____	Social Security #: _____
_____	Marital Status: _____
City, State, Zip: _____	Referring Physician: _____
Phone: (____) _____ []Home [] Work []Mobile	Primary Care Physician: _____
Phone: (____) _____ []Home [] Work []Mobile	
Phone: (____) _____ []Home [] Work []Mobile	IF MARRIED, NAME OF SPOUSE
Patient's Employer:	Spouse's Name: _____
Employer Name: _____	DOB: _____ SSN: _____
Phone: _____	IF PATIENT IS A CHILD, NAME OF MOTHER & FATHER:
Employer Address: _____	_____
Occupation: _____	CHILD LIVES WITH: MOTHER / FATHER
IN CASE OF EMERGENCY, CONTACT: (Someone in another household, i.e., grandparent, friend, etc.)	
Name: _____	Relationship: _____ Phone: _____
DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? IF YES, PLEASE LIST: _____	

PRIMARY INSURANCE

NAME OF PERSON CARRYING INSURANCE: _____

GUARANTOR PHONE: _____ SS#: _____ DOB: _____

YOUR RELATIONSHIP TO PERSON CARRYING INSURANCE: _____ COPAY: _____

PLACE OF EMPLOYMENT OF PERSON CARRYING INSURANCE: _____

NAME OF INSURANCE CO : _____ EFFECTIVE DATE: _____

INSURANCE I.D.#: _____ GROUP #: _____

ADDRESS TO SEND CLAIM: _____

SECONDARY INSURANCE

NAME OF PERSON CARRYING INSURANCE: _____

GUARANTOR PHONE: _____ SS#: _____ DOB: _____

YOUR RELATIONSHIP TO PERSON CARRYING INSURANCE: _____ COPAY: _____

PLACE OF EMPLOYMENT OF PERSON CARRYING INSURANCE: _____

NAME OF INSURANCE CO : _____ EFFECTIVE DATE: _____

INSURANCE I.D.#: _____ GROUP # : _____

ADDRESS TO SEND CLAIM: _____

AUTHORIZATION TO PAY INSURANCE BENEFITS & RELEASE INFORMATION TO INSURANCE COMPANY

I hereby authorize payment directly to Partners in Women's Health. I understand I am financially responsible for charges not covered by this authorization. I authorize Partners in Women's Health to release information required to complete my insurance claim.

PATIENT OR GUARDIAN'S SIGNATURE: _____ DATE: _____