Women's Health associates

803.648.0803
121 Aurora Place, Suite A
Aiken, SC 29801

Name _____ D.O.B. _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Phone # (____)_____ Work/Daytime # (____)_____ Mobile # (____)_____

Email Address: _____

SSN # _____ (Your SSN is used for insurance and patient identification purposes only)

Marital Status: S M D W

Race: Caucasian African American Native American Asian Latino/Hispanic Other

Patient Employer _____ Occupation _____

Spouse/Legal Guardian _____ SSN # _____ D.O.B. _____

Emergency Contact _____ Relation _____

Phone # (____)_____ Primary Care Physician _____

I authorize Women's Health Associates to furnish information to insurance carriers concerning my illness and treatments. I assign to the physician all payments for medical services rendered. I understand that I am personally responsible for my bill. This assignment is in effect until revoked by me in writing.

_____ _____
Signature of Patient or Guardian Date

MEDIGAP (For Medicare Patients Only)

I assign to the physician all Medigap payments for medical services rendered. I understand that I am personally responsible for my bill. This assignment is in effect until revoked by me in writing.

_____ _____
Signature of Patient or Guardian Date