NAME_____ D.O.B. _____ AGE _____

ADDRESS _____ CITY_____ STATE _____ ZIP CODE_____

PHONE # _(____)_____ WORK/DAYTIME # _(____)_____CELL# _(____)_____

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 OTHER

PATIENT EMPLOYER _____ OCCUPATION _____

SPOUSE/PARENT'S NAME _____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