

Patient Information

Last Name: _____ First Name: _____ MI: _____
 Social Security #: _____ Sex: ♂M ___ ♀F ___ Date of Birth: ____/____/____
 Street Address: _____ E-mail Address: _____
 City: _____ State: _____ Zip: _____
 Home #: _____ Work #: _____ Cell #: _____
 Place of Employment: _____ Phone# of Employer: _____
 Marital Status: S ___ M ___ D ___ W ___ If Minor, Name of Parent or Guardian: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Preferred Pharmacy: _____ Address: _____ Phone: _____
 How did you hear about the practice? Friend/Hospital/Insurance/Other: _____
 Are you a Smoker: Yes No History of Diabetes: Yes No History of Cancer: Yes No
 Would you like an Advance Directive Form? Yes No Referring Provider: _____

Primary Insurance Information

Insurance Company: _____ Phone #: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Insurance ID#: _____ Group#: _____ Co-payment \$: _____
 Policy Insurance holder Info (if not self) Name: _____ Phone#: _____
 Relationship to Patient: (e.g., Spouse, Parent, Legal Guardian or Self if applicable) _____
 Address: _____ City: _____ State: _____ Zip: _____
 Social Security #: _____ Date of Birth: ____/____/____ Sex: ♂Male ___ ♀Female ___
 Place of Employment: _____ Phone# of Employer: _____

Secondary Insurance Information

Insurance Company: _____ Phone #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Insurance Policy ID#: _____ Group#: _____ Co-payment \$: _____
 Policy Insurance holder Info (if not self) Name: _____ Phone#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Social Security #: _____ Date of Birth: ____/____/____ Sex: ♂Male ___ ♀Female ___
 Place of Employment: _____ Phone# of Employer: _____

I authorize payment of Medicare or my present insurance carrier benefits be made directly to Civista Women's Health Center for services furnished to me by the provider. I authorize the release of any medical information about me to the holder to determine benefits payable for related services. I am aware that I am responsible for any unpaid balance regardless of insurance status, and also for any fees or charges incurred for returned checks, or should my account be turned over to a collection agency for non-payment of services. I acknowledge my responsibilities as a member of my insurance carrier and will comply with applicable co-payments, co-insurances, and physician requirements at the time of service.

Signature of Patient or Guardian

Date

If Guardian, Please State Relationship to Patient

Print Name