For Internal Use Only
PT ID Number
Last Verified ___________

Visit our website at: www.womenshealthct.com

Patient Information

Last Name ____________ First Name ____________ M.I. ______ Maiden or Nickname ____________

Street Address ____________ Apt. ______ City ____________ State ______ Zip ______

Birth Date ____________ Race ____________ Ethnicity ____________ Preferred Language ____________

Social Security # ____________ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other

Home Phone # ( ) - Work Phone # ( ) - Ext. ______ Cell Phone # ____________

E-Mail Address ____________ May we E-mail you? ☐ Yes ☐ No

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ■ Yes ■ No

May we examine your medIcal record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Patient's Employer Information

Employer Name ____________ Employer Phone # ____________

Employer Address ____________
Street City State Zip

Occupation ____________ If Student ☐ Full Time ☐ Part Time School ____________

Insurance Information - Primary / Secondary / Other Do you have health insurance? ■ Yes ■ No

Primary Insurance ____________ **Copy of Card? ☐ Yes ☐ No**

Subscriber ____________ Relationship ____________

Secondary Insurance ____________ **Copy of Card? ☐ Yes ☐ No**

Subscriber ____________ Relationship ____________

Spouse's Or Parent's Information (If Patient is covered by Spouse's / Parent's Insurance)

Name ____________ Birth Date ____________ SS# ____________

Employer ____________ Employer's Phone # ( ) -

Employer Address ____________

Emergency Information: List nearest relative preferably not living with you.

In case of an emergency, we may contact: ( ) -
Telephone Number Relationship to Patient

____

Other

Primary Care Physician: ____________ Primary Physician In This Office: ____________ Referring Physician: ____________

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all costs including attorney's fee, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

____
Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations. Medicare Recipients Sign Both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

____
Patient's Signature Date

Notice of Privacy: ☐ Received ☐ Refused ____________
Signature of Patient or Parent of Minor Date

May release protected health information to: ____________
Name Relationship

Pharmacy Name and Address: ____________

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