PATIENT INFORMATION:

____
Chart # (For Internal Use Only)

NAME: ____
LAST NAME FIRST NAME M.I. LIKES TO BE CALLED...

ADDRESS: ____
STREET CITY STATE ZIP CODE

HOME PHONE (505) - WORK PHONE (505) - CELL PHONE (505) -

BIRTH DATE ____/____/____ MARITAL STATUS: S M W D OTHER SOC. SEC # - -

AGE: __________ WHOM MAY WE THANK FOR REFERRING YOU? ______________________

PATIENT EMPLOYED BY: ______________________ OCCUPATION: ______________________ RELIGION ______________________
(OPTIONAL)

SPOUSE'S NAME: ______________________ SPOUSE EMPLOYED BY: ______________________ OCCUPATION: ______________________

IN CASE OF EMERGENCY CONTACT: ______________________ PHONE (505) - RELATIONSHIP: __________

PRIMARY INSURANCE INFORMATION:

PERSON RESPONSIBLE FOR ACCOUNT: NAME: ____
LAST NAME FIRST NAME M.I.

RELATION TO PATIENT: ______________________ BIRTH DATE ____/____/____ SOC. SEC # - -

(TAPE COPY OF INSURANCE CARD HERE - Internal Use Only)

SECONDARY INSURANCE INFORMATION:

(TAPE COPY OF INSURANCE CARD HERE - Internal Use Only)

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with the above referenced Insurance company(ies) and assign directly to Women's Pelvic Specialty Care, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance and I further agree that in the event payment for my services are denied by my insurance because of my failure to follow the guidelines and/or obtain required documents and/or referrals, that I will be responsible for the charges connected with my services. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ____/____/____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE