

PATIENT INFORMATION FORM [] New [] Change

ID#: _____

First Name	Middle Initial	Last Name	Maiden Name
Address			E-mail Address
Zip	City		State
Home Phone ()	Work Phone ()	Extension	OK to call work? Yes/No
Cell Phone ()			
Birth Date	Age	Social Security #	
Drivers License #		Your Occupation	
Your Employer		Employer's Address	
Spouse's Name		Spouse's Birth Date	
Spouse's Social Security #		Spouse's Occupation	
Nearest Relative not living with you		Relative's Phone ()	
Emergency Contact		Emergency Phone ()	
Primary Care Physician		Pharmacy & City	
Your Insurance Company		Subscriber's Name SS# and Date of Birth	
ID#		Group #	

How did you hear about us? (F)riend, neighbor, (N)ewspaper ads, (D)octor/dentist, (H)ospital or (I)nsurance carrier (circle one)

Definition: *practice* is defined as any entity of the Women's Health Center of Hunterdon CountySM which is comprised of Affiliates in Ob/Gyn, P.A., Hunterdon Diagnostics, P.A. and the Women's Mammography Center, P.A.

1. Your insurance is a contract between you, your employer and the insurance company. The practice is not involved in this contract.
2. Most insurance carrier's reimbursements are based on an arbitrary "fee schedule", which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance carriers arbitrarily select certain services they will not cover.
4. All our fees are available upon request
5. Copays, if applicable, are printed on your insurance card and are due at the time of service.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read this information and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information.

MEDICAL INFORMATION RELEASE – MEDICAL EXAMINATION CONSENT

I hereby authorize the practice to release any medical information regarding my care, should it be necessary for the processing of my claim(s). Payment of medical benefits from the insurance companies should be made directly to the appropriate medical provider where applicable, as in cases of surgery or pregnancy. A photocopy of this authorization may be honored. I hereby give my consent to a medical examination.

Signature (parent if minor) _____ Date _____

UPON COMPLETION, RETURN THIS FORM TO THE OFFICE STAFF WITH YOUR INSURANCE IDENTIFICATION CARD