

Women's Center for Total Health, Inc.

PATIENT INFORMATION - PLEASE PRINT					TODAY'S DATE
LAST NAME		FIRST NAME		M.I.	D.O.B
STREET ADDRESS				SOCIAL SECURITY #	
CITY		STATE	ZIP	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> DIV. <input type="checkbox"/> SEP. <input type="checkbox"/>	
HOME PHONE		WORK PHONE		CELL PHONE	
EMPLOYER NAME		ADDRESS			OCCUPATION

SPOUSE / PARENT OR RESPONSIBLE PARTY					
LAST NAME		FIRST NAME		M.I.	D.O.B
STREET ADDRESS					
CITY		STATE	ZIP		
HOME PHONE		WORK PHONE		CELL PHONE	
EMPLOYER NAME		ADDRESS			OCCUPATION

REFERRED BY: <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER		PRIMARY CARE PHYSICIAN			
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PRIMARY INSURANCE					
INSURANCE COMPANY				PHONE	
ADDRESS					
CITY/STATE/ZIP					
I.D. NUMBER		GROUP NAME OR NUMBER		FIRST NAME	
INSURED'S LAST NAME		DATE OF BIRTH		SOCIAL SECURITY #	
RELATIONSHIP TO GUARANTOR <input type="checkbox"/> SELF <input type="checkbox"/> WIFE <input type="checkbox"/> HUSBAND <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER				EMPLOYER INS. PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO	

EMERGENCY INFORMATION					
NAME		RELATIONSHIP	HOME PHONE	WORK PHONE	
STREET ADDRESS		CITY/STATE/ZIP			OCCUPATION

HOW WOULD YOU LIKE OUR OFFICE TO CONTACT YOU? PLEASE GIVE THREE PHONE NUMBERS.

1. _____ 2. _____ 3. _____

PAYMENT AGREEMENT & INFORMATION RELEASE	
<p>I understand it is my responsibility to provide correct insurance for EACH date of service. I accept responsibility for any monies due if any of the information I have supplied is incorrect. I also understand that if for any reason my insurance will not cover this claim, I will be held responsible for my bill. I give my consent to discharge any and all medical information necessary to process my insurance claim. I hereby authorize payment of insurance benefits to be paid directly to my treating physician or provider for service rendered. In the event of a collection or legal action, I will be responsible for any and all fees incurred.</p>	
_____ Patient/Responsible Party Signature	_____ Date