

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

HOME PHONE _____ BIRTHDATE _____

MARITAL STATUS: S _____ M _____ D _____ SEP _____ W _____

ADDRESS _____ APT #/LOT # _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ - _____ - _____ DRIVER'S LICENSE # _____

HUSBAND'S OR PARENT'S FULL NAME _____

PRIMARY INSURANCE

COMPANY _____ POLICY HOLDER _____
POLICY # _____ GROUP # _____

SECONDARY INSURANCE

COMPANY _____ POLICY HOLDER _____
POLICY # _____ GROUP # _____

IS THE PATIENT ON MEDICAID? _____ MEDICARE? _____

PATIENT'S EMPLOYER _____ PHONE # _____

HUSBAND'S EMPLOYER _____ PHONE # _____

CONTACT PERSONS IN CASE OF EMERGENCY (OTHER THAN SPOUSE)

- 1. _____ ADDRESS/PHONE # _____
- 2. _____ ADDRESS/PHONE # _____
- 3. _____ ADDRESS/PHONE # _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CARDS TO THE OFFICE PRIOR TO SURGERY.

ALL PROFESSIONAL CHARGES RENDERED ARE CHARGED TO THE PATIENT. DIAGNOSTIC RECEIPTS WILL BE FURNISHED UPON REQUEST SO THAT YOU MAY BE REIMBURSED BY YOUR INSURANCE COMPANY.

AUTHORIZATION OF ASSIGNED BENEFITS AND RECORDS RELEASE

I AUTHORIZE DR. THOMAS GIEBMANN TO RELEASE MEDICAL INFORMATION TO SUBMIT INSURANCE CLAIMS AND FOR OTHER PHYSICIAN'S REQUESTS RELATING TO MY MEDICAL CARE. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR ANY UNPAID PROFESSIONAL CHARGES DIRECTLY TO PROFESSIONAL WOMEN'S HEALTHCARE, P.A. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

SIGNATURE

DATE