

Women's Health Care

in San Diego
A Medical Corporation

Patient Information: Account # _____
 Patient's Name: _____ Age: _____ Birth Date: _____
 Maiden Name: _____ Home Phone # () _____
 Home Address: _____ Cell Ph. Or Pager # () _____
 City: _____ State: _____ Zip Code: _____ Work # () _____ Ext. _____
 Mailing Address: (If Different From Above): _____
 Social Security #: _____ Driver's License #: _____ State: _____ Marital Status: S / M / D / W
 If Minor, Name of Parent or Guardian: _____ Phone: () _____
 Social Security # of Parent/Guardian: _____ Drivers License #: _____ State: _____

Primary Care Doctor: _____ Phone: () _____ Fax: () _____
 Who Referred You To This Office? _____ Name of Person Who Referred You: _____
 Name of Physician you previously saw for this condition: _____ Phone: () _____

Emergency Contact Information: Contact: _____ Relationship: _____ Phone: () _____

Patient's Employment Information (Or Responsible Party, If Minor):
 Name of Employer: _____ Occupation _____
 Address: _____ City: _____ State: _____ Zip Code: _____

Spousal Information:
 Spouse Name: _____ DOB: _____ Social Security #: _____

Employer's Name: _____ Occupation: _____ Phone: () _____

Health Insurance Contracted Labs: Unilab: _____ Quest: _____ Sharp: _____ Other: _____
**** Call your Health Insurance Company before appointment to verify contracted lab information. ****
 Health Insurance: Yes / No If yes, is it an: HMO: _____ PPO: _____ OTHER: _____
**** Bring Insurance Card on date of your appointment otherwise payment for services will be required. ****

Would you like an Advance Directive Form? Yes / No
 I agree that payment is to be made at the time the service is rendered unless prior arrangements are made. I authorize Women's Health Care to bill my insurance and to receive the payment for Medical benefits directly and to furnish information to the insurance carrier concerning my illness and treatments. Regulations pertaining to medical assignment of benefits apply. I understand that I am responsible for all amounts not covered by my insurance as well as services provided outside of the office (Pap Interpretations, Labs, Ultra Sounds etc.). I further agree that in the event of non-payment, I will bear the cost of collections and court costs and reasonable legal fees, should action be required. I agree that a photocopy of the authorization shall be valid as an original.

Patient Signature: _____ Date: _____

Signature of Responsible Party for Payment: _____ Date: _____

Acknowledgement of Receipt of Privacy Notice: (Complete this section below at your appointment time in the office.)
 I have been presented with a copy of Women's Health Care in San Diego A.M.C., Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and request the following restriction(s) concerning the use of my personal medical information:

Patient Signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., Spouse, Parent, Legal Guardian)

Relationship: _____ Witnessed by: _____