Patient Information **Alabama Women's Health Care** Date: _____

Patient Information

Patient's Name (last, first, middle) _____

Street _____

City, State, Zip_____Home Phone_____Cell Phone_____

Sex_____Birth Date_____Age_____SSN_____Driver's Lic #_____Marital Status_____

Patient's Employer_____Occupation_____Work Phone_____

Spouse's Name _____

Spouse's Employer_____Occupation_____Work Phone_____

Emergency Contact

Contact's Name_____Relationship_____Phone_____

Referring Physician

Referring Physician_____Phone_____

Insurance Information

Insurance #1_____Copay_____

Contract #_____Group #_____

Name of Insured_____Relationship to Patient_____

Sex_____Birth Date_____SSN_____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____Date_____

I hereby authorize Alabama Women's Health Care to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Alabama Women's Health Care or to the party who accepts assignment. I certify that the information I have regarding my insurance coverage is correct, In the event of outside collections, I agree to pay all collections costs, including a reasonable attorney fee.

Signature_____Date_____

Email Address_____