Accent on Women's Health Patient Information Form

Please provide the following information for our records. To help minimize errors, please print legibly. Be sure to read the authorization and acknowledgement at the bottom of the form and sign and date it. Thank you for trusting us with your care.

PATIENT

Patient Name (Last, First Middle)	Also Known As / Other Name	Social Security Number	Date of Birth	Acct

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Work Phone	Email

Employer	Driver's License Number / State	Primary Language (if not English)

Marital Status	Race	Ethnicity
☐ Married ☐ Single ☐ Widowed ☐ Life Partner ☐ Divorced ☐ Separated	☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Native Hawaiian ☐ Pac. Islander ☐ Other ☐ Prefer not to answer	☐ Hispanic/Latino ☐ None/Other

EMERGENCY CONTACT

Name	Relation to Patient

Home Phone	Work Phone	Cell Phone

Date of Birth	Employer

SECOND (EMERGENCY) CONTACT

Name	Relation to Patient

Home Phone	Work Phone	Cell Phone

Comments

PRIMARY INSURANCE

Insurance Plan Name	Phone

Address

City	State	Zip

Group Number	ID#	Effective Date

Subscriber Name	Relation to Patient

Subscriber Employer	Subscriber Date of Birth

SECONDARY INSURANCE

Insurance Plan Name	Phone

Address

City	State	Zip

Group Number	ID#	Effective Date

Subscriber Name	Relation to Patient

Subscriber Employer	Subscriber Date of Birth

INSURANCE AUTHORIZATION / PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby authorize Accent on Womens Health to furnish my insurance company all information which said insurance company may request concerning my present claim. I hereby assign to the practitioner all money to which I am entitled for expenses relative to the services performed from time to time but not to exceed my indebtedness to said practitioner. I understand that I shall be responsible to pay such sums as are now or may become due for services rendered to me. It is also understood that in the event my insurance company does not make payment or only partial payment, this obligation to pay shall be my responsibility.

Signature ______________________ Date ____________