PARADISE VALLEY WOMEN'S CARE

PATIENT INFORMATION FORM

Patients must complete this form annually, per government regulations

Last Name: __________________________ First Name: _____________________________ MI_____

Birth Date: _______________________SSN: ______-_____-________(we need this to deliver lab result messages)

Mailing Address: ____

City: _______________________________State: ________________Zip Code_________________

Home Ph: (_____)_____-________Cell Ph: (_____)_____-________Work PH: (_____)_____-________

Employer: _________________________________Occupation: __________________________________

Primary Care Physician: ______________________ Referring Physician: _________________________

Spouse's Name: ______________________________Employer: __________________________________

IN CASE OF EMERGENCY please notify…(someone not living with you)
Name: _____________________Relationship ________Home: ____________Work/Cell___________

INSURANCE INFORMATION

Primary Insurance Company: __________________________________ Effective Date______________
Policy Holder's Name_______________________________ Birth Date___________ Co-Pay_________
Policy Holder's Social Security #_____-____-_______Policy #______________Group #___________
Relationship to patient____________________________Employer_____________________________
Secondary Insurance Company__________________________________ Effective Date ____________
Policy Holder's Name_______________________________ Birth Date___________ Co-Pay_________
Policy Holder's Social Security #_____-____-_______Policy #______________Group #___________

IT IS THE PATIENT'S RESPONSIBILITY TO CHECK AND KNOW INSURANCE COMPANY COVERAGE, BENEFITS AND CONTRACTED PROVIDERS

I understand that I am financially responsible for services rendered to me regardless of possible insurance coverage, including the balance after insurance payments. I am responsible for all charges related to services that my insurance plan deems excluded from coverage. I authorize payment under my insurance plan to be made directly to the provider accepting assignment. I authorize the release of all medical records covered by "The Privacy Act," necessary to process the claim or to assist any physicians who may be involved in my care.

I AUTHORIZE PV WOMENS CARE TO RELEASE MY MEDICAL INFORMATION (such as verbal instructions, Lab, or test results- Medical Records require a separate signed release) TO THE FOLLOWING (i.e. spouse, other family member, attorneys, etc.):

Name_________________________________ Relationship to Patient_________________________________

If we are unable to contact you in person, may we leave a message in reference to your Health Care: test results, medical information, and/or other, on your answering machine? ______ YES; or_______ NO __________ initials
Phone # where we can leave voicemail (_____)______-___________

I acknowledge "Patient Disclosure of Protected Health Information" made available to me: _______initials

Signature of Patient
And/or Guardian: ____Date_______________________