Total Woman
HEALTHCARE, P.A.

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____

Age: _____ Birth Date: _____ - _____ - _____ Martial Status: ❑ SINGLE ❑ MARRIED ❑ OTHER

Social Security: _____ - _____ - _____ Home Phone: _____

Email Address: _____

Cell Phone: _____ Patients Occupation: _____

Employed by: _____ Phone: _____ EXT: _____

Business Address: _____

City: _____ State: _____ Zip code: _____

Spouse's first name: _____ Last Name: _____ Birth Date: _____

Spouse's Occupation: _____ Employed by: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Pharmacy Name & Zip: _____

PRIMARY INSURANCE INFORMATION:

Name of Person Responsible for Insurance: _____

Relationship to patient:_____ Birth date: _____ Soc. Sec.: _____

Insurance Company Name: _____ Card ID #: _____

ASSINGMENT & RELEASE

I, the undersigned, (or my dependent, as insurance coverage with _____

(Name of Insurance Company)

And assign directly to Total Woman Healthcare, PS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In case an action is instituted to collect this note or any portion, thereof, the below named patient promises to pay all collection costs and additional sums as may be deemed responsible in said action, I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

X_____ _____ _____

PATIENT ORGAURANTOR SIGNATURE RELATIONSHIP DATE