Date: ___/____/_____

Pacific Women's Center
Physicians and Surgeons

PATIENT INFORMATION *(Please Print)*

Last Name | First | MI | Marital Status ☐ M ☐ S ☐ D ☐ W

Street Address | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

Home Phone ( ) | Cell Phone ( ) | Social Security Number | Birth Date | Age

Primary Care Physician | Referred by: ☐ Primary Care Physician ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Newspaper ☐ Other ☐ Website

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for Bill | Address | Phone Number ( )

Employer | Work Number ( )

PRIMARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address of Insured Party | City | State | Zip Code | Phone Number ( )

Name of Insured Party | Social Security Number | Birthdate | Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address | City | State | Zip Code | Phone Number ( )

Name of Insured Party | Social Security Number | Birth Date | Relationship to Patient

PERSON TO CONTACT IN CASE OF EMERGENCY

Name | Relationship to Patient | Phone Number ( )

I hereby authorize Pacific Women's Center, L.L.C., to furnish to your insurance company, employer or other payor, or their representatives, or either myself or the subscriber, or to the referring physician, all medical or financial information which may be requested concerning the patient's present illness, injury, or condition.

I hereby authorize Aetna Medicare to release information regarding any claim, assigned or unassigned, to Pacific Women's Center, L.L.C.

I hereby authorize my insurance benefits to be paid directly to Pacific Women's Center, L.L.C., and I understand that I am financially responsible for non-covered services. I agree to pay finance billing fee on any unpaid balance over 90 days.

Patient Signature ____________________ Parent/Guardian Signature ____________________ Date __________

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