

***Associated Women's Healthcare, LLP***  
**Obstetrics, Gynecology & Infertility**

Patient \_\_\_\_\_ Age \_\_\_\_ DOB \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
No. Street Apt. No. City State Zip

E-Mail Address \_\_\_\_\_

Married \_\_\_\_ Divorced \_\_\_\_ Single \_\_\_\_ Widow \_\_\_\_ Social Security No. \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Spouse's Name \_\_\_\_\_ DOB \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Spouse's Work Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_

Nearest Relative  
Not Living With You \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Referred To This Office By \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**NOTICE !! Patient is responsible for all office fees at time services are rendered.**

All insurance information must be provided when appointment  
is made or your appointment will be rescheduled.

**INSURANCE INFORMATION**

HOW MANY HEALTH INSURANCE COMPANIES ARE YOU COVERED UNDER? \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Thru your employer \_\_\_\_ Thru your spouse's employer \_\_\_\_ Other \_\_\_\_ Name of Ins. Co.:

Mail Claims To \_\_\_\_\_  
Street City State Zip

Group No. \_\_\_\_\_ I.D. # \_\_\_\_\_

OFFICE USE ONLY

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

I hereby permit Associated Women's Healthcare, LLP to release and furnish all medical and financial data released to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposed of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payers, or any organizations contracting with any of the above entities to perform such functions.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_