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*Obstetrics*Gynecology*Infertility*

Please note: So that we may maintain the most up to date and accurate information on our patients, we will request that you update this form at least once a year.

Patient Information

Name: First_____MI_____Last_____ Birthdate_____

Address_____Apt#_____City_____State_____Zip_____

Phone: Home_____Celll_____Work_____

Best Contact Number_____ Emergency Contact: Name_____Phone_____

Email address_____ Primary Care Doctor_____
(*Confidential Medical Information Will NOT be emailed.)*

Marital Status_____ SS#_____ Driver's License #_____

Race_____ Ethnic Group: Caucasian_____ African American_____Hispanic_____Asian_____Other_____

Preferred Language: English_____Spanish_____ Other (Please List)_____

Insurance_____Check One: ☐HMO ☐PPO ☐POS ☐Medicare ☐Medi-Cal ☐OTHER

Insured Name_____SS#_____

Patient's Relationship_____ID #_____

Please provide all insurance cards and a current, valid photo ID.

Please Answer the Following Questions:

1. Do we have permission to leave messages on your answering machine? ☐Yes ☐No

2. Do we have permission to leave messages with the person who answered the phone? ☐Yes ☐No

3. Do we have permission to contact you by Email? ☐Yes ☐No *(email will NOT be used for marketing)*

4. Who may we thank for referring you? _____

Medication Refill Policy
Please contact your pharmacy for medication refills. Your Pharmacy will fax a medication refill request to us which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request.

_____
Initials

The above information is true to the best of my knowledge. I hereby give lifetime authorization for my insurance/Medicare benefits to be paid directly to Women's Care OB/GYN Medical Group, Inc. I understand that I am financially responsible for any balance whether or not they are covered by insurance/Medicare. I understand that if I receive any payments due to Women's Care OB/GYN Medical Group, Inc. it is mo responsibility to immediately remit the payments to Women's Care OB/GYN Medical Group, Inc. I certify that I have no other insurance coverage. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a copy of this agreement shall be as valid as the original.

_____ _____ _____
Signed (Patient or Legal Guardian) Relationship Date