

Account # _____ Appt. Date _____ Provider: CD / LH Verified By: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I.:** _____

Address: _____ **Nickname:** _____

City: _____ **ST:** _____ **ZIP:** _____ **Phone:** _____ **Cell:** _____

SSN: _____ **DOB:** _____ **Marital Status:** S M Sep D W

Employer: _____ **Phone:** _____ **Ext:** _____

Address: _____ **Occupation:** _____

City: _____ **ST:** _____ **ZIP:** _____ **Email address:** _____

Referred by: _____

Primary Care Doctor: _____

SUBSCRIBER INFORMATION

Policy Holder Name: _____ **Relationship to Insured:** _____

Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Cell:** _____

SSN: _____ **DOB:** _____ **Age:** _____

Employer: _____ **Occupation:** _____

Address: _____ **Phone:** _____ **Ext:** _____

City: _____ **ST:** _____ **ZIP:** _____

INSURANCE INFORMATION

Individual Policy

Employer Group Policy

Primary Insurance Company Name: _____

Claims Mailing Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Customer Service Phone:#:** _____

Subscriber/Member ID#: _____ **Group/Account#:** _____

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

City: _____ **ST:** _____ **ZIP:** _____ **Phone:** _____

Subscriber/Member ID#: _____ **Group/Account#:** _____

Name, Address, and Phone of Friend/Relative not living with you: _____

I authorize any physician or hospital that has treated me in the past to release a copy of my medical records to Devoted to Women, PA. This shall specifically include information relating to psychiatric conditions, alcohol and/or drug abuse, and HIV testing results. I authorize Devoted to Women, PA to release any information contained in my medical record to my insurance company or another physician. This shall specifically include information relating to psychiatric conditions, alcohol and/or drug abuse, and HIV testing results. I authorize and instruct my insurance company(s) to pay all benefits and payments directly to Devoted to Women, PA. I understand that I am financially responsible for my account regardless of my insurance payments or benefits.

Signed: _____ Date: _____

Please allow us to make photocopies of your insurance card(s) and driver's license. This information will help us communicate more effectively with you and your insurance company. Thank you for your assistance and cooperation.