PINNACLE WOMEN'S HEALTHCARE – PATIENT INFORMATION FORM

Patient's Name: ____
Last First Middle

Address ____________________________________ Apt. # ___________
City: _____________________ State: ______________ Zip Code: ________
Home Phone: ____________________ Marital Status: __________________
Social Security No. ________________ Date of Birth: ___________ Age _____
Cell Phone ______________________ Work No ______________________
Employer ____
Spouse's Name ____
Last First Middle

Social Security No. ________________ Date of Birth: ___________ Age _____
Cell Phone ______________________ Work No ______________________
Employer ____
Authorization to treat minor child _____________ [] Mother [] Father [] Guardian
Person to notify in case of emergency (not at same address):
Name: ____________________________________
Phone Number: ______________________ Relationship: _______________

How were you referred to our Practice:
[] Insurance [] Phone Book [] Web site [] Friend [] Family [] Other
Referring Physician: ____
Primary Care Physician: ____

INSURANCE INFORMATION
Please give your insurance card to the receptionist so we may keep a copy on file.
Primary Insurance ____
Policy ID Number __________________ Group Number __________________
Policy Holder Name _______________ Relationship to you [] Self [] Spouse [] Child
Social Security No: ______________________ Date of Birth: _____________
Place of Employment: ____
Secondary Insurance: ____
Policy ID Number __________________ Group Number __________________
Policy Holder Name _______________ Relationship to you [] Self [] Spouse [] Child
Social Security No: ______________________ Date of Birth: _____________
Place of Employment: ____

i hereby authorize Pinnacle Women's Healthcare to furnish all information to insurance carriers and health care providers concerning my illness and treatments and assign all payments for medical services rendered to myself or my dependents to Pinnacle Women's Healthcare. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Insurance.

Signature: ________________________________ Date: _____________