

MY INFORMATION IS CORRECT	
DATE	SIGNATURE

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ AGE _____ SEX _____ DOCTOR _____

SOCIAL SECURITY NUMBER _____ REFERRED BY _____

HOME PHONE _____ CELL _____ WORK _____

EMPLOYER _____ ADDRESS _____ OCCUPATION _____

MARITAL STATUS _____ IF MARRIED, NAME OF SPOUSE _____

EMERGENCY CONTACT _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE CO. _____ MAILING ADDRESS _____

SUBSCRIBER _____ SEX _____ DATE OF BIRTH _____

SUBSCRIBER'S EMPLOYER _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____

EFFECTIVE FROM _____ EFFECTIVE TO _____

MEMBER ID NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE CO. _____ MAILING ADDRESS _____

SUBSCRIBER _____ SEX _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____ EFFECTIVE FROM _____

MEMBER ID NUMBER _____ GROUP NUMBER _____

PATIENTS RIGHTS AND NOTICE OF PRIVACY PRACTICES: I understand and acknowledge that I have been offered information regarding my rights and responsibilities as a patient and a copy of the Notice of Privacy Practices.

_____ INITIALS

I hereby authorize my insurance benefits to be paid directly to Barrington Health Care for Women, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. To my knowledge, the above is true and correct.

PATIENT SIGNATURE _____ DATE _____