CENTER FOR WOMEN'S HEALTH
PATIENT INFORMATION SHEET

capitalhealth
Minds Advancing Medicine

Date: _____ /_____ /_____

PATIENT INFORMATION

Name: _____ Age: _____ Date of birth: _____ / _____ / _____

Address: _____

_____

Home phone: _____ Mobile phone: _____

Social security number: _____ Email address: _____

May we send you email on health related topics and programs? ☐ YES ☐ NO

Marital status:

☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Married. Spouse's name: _____

Employer: _____ Work Phone _____

Work address: _____

Pharmacy name / phone number: _____

Referred by: _____

Parent/guardian: (person to be billed if patient is under age 18)

Name: _____ Home phone: _____

Address: _____

_____

Date of birth: _____ /_____ /_____ Social security number: _____

Employer: _____ Work Phone: _____

Work address: _____

MEDICAL INSURANCE INFORMATION

Primary insurance company: _____ Group #: _____

Policy/ID #: _____ Patient relationship to subscriber: _____

Subscriber's name: _____ Date of birth: _____ / _____ / _____ SS#: _____

Secondary insurance company: _____ Group #: _____

Policy/ID #: _____ Patient relationship to subscriber: _____

Subscriber's name: _____ Date of birth: _____ / _____ / _____ SS#: _____

Other insurances? _____

Subscriber information: (if different from Patient or Parent/Guardian) ☐ Primary ☐ Secondary

Address: _____

_____

Employer: _____ Work Phone: _____

Work address: _____

(Please complete other side.)

Have you been seen at The Center for Women's Health or the Hamilton Physicians Group? ☐ YES ☐ NO

In case of emergency, contact: _____ Relationship: _____

Home phone: _____ Work phone: _____ Other: _____

Assurance of Confidentiality: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law, and as outlined, below.

Please read, sign, and date the following to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services. I authorize the release of medical history , information, or records concerning my diagnosis and treatment by Hamilton Physicians Group required to substantiate or explain insurance claims filed, and I authorize payment directly to Hamilton Physicians Group and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Hamilton Physicians Group for any services furnished to me by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related service.

_____

Signature of Patient or Authorized Person (Address/Relationship)

____ /____ /____ _____

Date Time

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf directly to Hamilton Physicians Group for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) _____ _____ any information needed to determine these benefits payable for related services.

_____

Signature of Patient or Authorized Person (Address/Relationship)

____ /____ /____ _____

Date Time

I have read and reviewed the attached, and there are no changes to the information provided.

(To be re-signed once a year)

Signature: _____ Date: ____ /____ /____ Time: _____

Signature: _____ Date: ____ /____ /____ Time: _____

Signature: _____ Date: ____ /____ /____ Time: _____

Signature: _____ Date: ____ /____ /____ Time: _____